Action on Social Determinants of Health:

Case Studies from Australia

Acknowledgements

CONTENTS

CHAPTER 1 – INTRODUCTION TO THE CASE BOOK

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<u>Introduction</u>

The importance of intersectoral policy action on social determinants of health (SDH) has been recognised in Australian public policy, including health policy, by governments at various levels and of diverse political orientations. This case book aims to provide description of and lessons from Australian policy action on SDH from six jurisdictions, including the policy imperatives and the drivers for action. The case studies represent national and state/territory approaches, and offer reflections on both policy and programmatic actions.

This chapter sets the scene with overview of the historical and contemporary system context for developments in these various jurisdictions, including how they relate to global developments. The six case studies are introduced to point to key themes and issues emerging from these cases, which are analysed further in the concluding chapter.

<u>Australian context</u>

Australia is geographically large (being the sixth largest country in the world) but has a relatively small population of 22 million, with the majority concentrated in cities on the eastern states. As the 12th largest economy in the world, Australia enjoys a high per capita income and good life expectancy (of 84 years for females and nearly 80 for males). As a country of immigrants, a quarter of the Australian population is born elsewhere and over 40% of people have at least one overseas-born parent, while Aboriginal and Torres Straits Islander (ATSI) peoples make up about 2.5% of the overall population The overall good health status is underpinned by a national health insurance system that provides for universal coverage and a well-established social protection system. However, there exist health inequalities – between socioeconomic groups, between rural and urban communities, between ethnic groups, and between the general population and Aboriginal and Torres Strait Islander peoples. For example, life expectancy at birth for ATSI people born in 2005-07 was estimated to be 9.7 years lower for females and 11.5 years lower for males compared to non-Indigenous Australians (AHMAC 2012).

A federalist system, Australia's 6 states and 2 territories have the constitutional responsibility for service delivery with the Commonwealth Government exercising only powers and responsibilities as specified in the Constitution. A system of intergovernmental financial transfers assures fiscal equalization to enable the states/territories to meet the community's needs in equitable manner, albeit often within quite different frameworks for public administration, including in the health sector. National health policy coordination occurs via intergovernmental agreements and forums at the level of prime minister and first ministers (COAG, or Council of Australian Governments), standing committee of health ministers, and permanent heads of health departments (AHMAC – Australian Health Ministers' Advisory Council).

Increased attention to population health in Australian health policy could be traced to the 1980s, when a renaissance in public health saw the establishment of new institutions and programs at federal and state levels (Lin et al 2007). Along with Medicare (the national health insurance scheme), the national health statistics agency (AIHW – Australian Institute of Health and Welfare),

the peak body for presenting the voice of health consumers (Consumer Health Forum, or CHF), were established at the national level. Additional investments in health promotion occurred at the state-level with health promotion foundations set up through tobacco hypothecation.

The Better Health Commission in its report in 1985 recognised the importance of intersectoral action to address premature mortality related to chronic conditions (such as heart disease, cancer and injury), while multiple policy and strategy developments at national and state levels (including National Aboriginal Health Strategy, National Women's Health Program, National Campaign Against Drug Abuse, National HIV Strategy, etc) from the mid-1980s onwards recognised the importance of the social determinants of health .   The concepts expressed through the Ottawa Charter for Health Promotion (WHO 1986) underpinned these developments, though not always explicitly recognised. State public health acts promulgated new practices such as municipal public health plans and health impact assessment. Additionally, state-based community health services, drawing from the concepts in the Declaration of Alma-Ata provided not only preventive services and care coordination but also were engaged in community development and policy advocacy.

A review by the National Health and Medical Research Council (NHMRC) in the mid-1990s (NHMRC 1997) suggested that the Australian public health successes in controlling tobacco, HIV, and road safety were attributable to having strategic direction, technical expertise, and supportive implementation structures and provided a model for global learning.

Over the past 25 years, these policies and programs have laid a strong foundation of technical expertise, program implementation experience, and community and stakeholder networks. These policy advocacy coalitions have played, and continue to play, important roles at state and national levels

Over this time, there has also been a broader interest in Australian public administration in terms of recognising the importance of adopting whole of government approaches to persistent and intractable challenges, be they related to environmental or social issues. Area assistance programs, place management programs, urban/neighbourhood renewal programs implemented by state governments were all attempts to recognise locational disadvantage and to bring program and sector silos together to work in a more integrated and holistic way, in order to respond to the needs of communities. At the federal level, trials have been undertaken where governments and communities worked together to address the needs of Aboriginal and Torres Strait Island peoples through place-based approaches.

Since 2007, a further series of national reforms have occurred to alter the landscape of public administration. Commonwealth-state financial relations moved to a 'pay for performance' model, whereby states/territories receive facilitation funding and reward payments for achieving agreed reform targets. In the social sector, reforms were instituted for early childhood, education, housing, aged care, primary care, ATSI health, preventive health, and health system governance and financing. The National Partnership Agreement on Preventive Health (NPAPH), announced in late 2008, is concerned with stemming the rise in chronic diseases through promoting healthy behaviours. This has led to the development of many community-based and multisectoral initiatives, many of which target the needs of socioeconomically disadvantaged communities and help build capacity for health promotion. Some of the examples which are not covered in this case book include development of local prevention systems through local government in Victoria, policy

Inequalities) and put a focus on social determinants of health. Health Action Zones were the manifestation of a place-based approach for intersectoral action at the local level. These efforts recognised that health inequalities were 'wicked problems' – i.e. complex, hard to resolve, keep shifting, have multiple causes, and cut across jurisdictions (Rittel and Webber 1973).

Elsewhere in Europe (Pollitt 2010), there have been attempts to implement one-stop shops for citizens and joined-up service to businesses in Italy, intersectoral policies and programs in Finland covering health promotion, aging, energy, and other areas, and having a public health minister as a coordinating minister in Sweden. In the Asia-Pacific region (Rani et al 2012), intersectoral commissions have been established for public health (in Mongolia), for health promoting environment (in Malaysia), and for non-communicable diseases (NCDs) (in Fiji and the Philippines). These exercises may be variously driven either by ideals or by utilitarianism. The former recognised the importance of whole-of-society approaches, through participation, deliberative democracy, and community system strengthening, while the latter aimed variously to increase efficiency in public administration, to enhance popular appeal of governments, or to improve policy coherence.

These experiences point to different ways in which joined-up government can be effected (Mulgan 2010). Top-down reliance on government authority is effective but dependent on commitment of leaders. Cooperation between departments and agencies based on shared conviction for the need to change may be more sustainable, but also require a supportive authorising environment. Bottom-up collaboration from the community can focus on real problem-solving but scaling up can be more difficult. Legislative provision for cross-cutting ways of working is an effective approach to embed new governance practices, but its form and achievement is dependent on the political climate.

The attempts over the years to implement joined-up government point to some common barriers and enablers (Blackman et al 2010). Programmatic focus, operational structures and concern for 'core business' represent the hard barriers, while clear mandate, central leaderships, and shared understanding of objectives and outcomes are typically the enablers. Successful working across boundaries will often require vertical hierarchies to support horizontal collaborative networks, having clients involved, space for policy entrepreneurs, and adopting a continuum of connectedness, ie from communication (sharing information) to cooperation (sharing resources) to coordination (sharing work) to collaboration (sharing responsibility) (Gill 2010).

Adoption of intersectoral strategies, particularly place-based approaches, reflects a shift from institution- or program-centred outlook to one that places people and communities at the centre. This is underpinned by the recognition that complex social systems require new approaches. Historically, bureaucracies used command and control systems to effect action up and down hierarchies, and program coordination mechanisms were developed in order to ensure systems were in place to address complications arising from different administrative and organisational frameworks. With complex social issues, where both problems and solutions involve multiple actors within and beyond government, there is recognition that no one has control over the system. Instead, organisations and others coalesce around shared interests. As such, the development of partnerships and networked approaches is likely to be more productive in bringing about change (Burris et al 2005). Such partnerships are likely to involve changing alignments between state, market and civil society, representing a shift from government direction to network governance.

Such a networked approach would span both 'vertical governance' (across different levels of government) and 'horizontal governance' (across different sectors).

However, while the need for intersectoral action to address SDH is well understood in theory, there are a range of practical challenges for policy-makers (Exworthy and Hunter 2011). These include lack of simple solutions, limited understanding of causal pathways, availability of stratified and small area data, time scale needed to achieve results, need for multiple sectors to work in concert, levers at different levels of government, and competing policy agendas. From this perspective, the establishment of intersectoral governance mechanisms and processes is a key pathway forward (McQueen et al 2012).

Consistent with the WHO's call for more effective stewardship for health (WHO 2000), other international organisations (eg United Nations Development Program (UNDP), World Bank) have urged for more attention being paid to effective governance – being transparent, accountable, participatory, responsive. There is an increasing range of international experiences on joined-up policy making, on how the health sector can work both 'upstream' and 'downstream' in terms of working across the continuum from primary prevention to care for the ill.

Experiences of intersectoral governance for health in Europe may be seen through a range of mechanisms at the level of parliament, government, and bureaucracy, but how government may delegate authority to statutory bodies, and the interface between governmental processes and civil society are also increasingly important features (McQueen et al 2012). These mechanisms may lead to a range of collection action along the different phases of the policy cycle, ranging from initial policy agenda setting and strategy development through to tangible implementation actions as joint budgets and legislation.

Earlier studies in intersectoral action suggest that there are pre-conditions for effective collaboration (Kickbusch 2010). These include: a need to work together to achieve their shared goals, there are opportunities to work together, organisations have the capacity (resources, skills, knowledge) to take action, parties have developed a relationship, and the planned action is well conceived. Monitoring and evaluation would also help to sustain actions and outcomes. It can be expected that successful intersectoral governance would need to satisfy these conditions.

The biggest challenge for horizontal governance, however, is likely to be in its ongoing implementation, so that policy practice and program delivery all reflect joined-up thinking (Hyde 2008). While governments and ministers have responsibilities for strategies, it is the senior level of the public service that has to support policy and program development, the mid-level bureaucrats who have to implement protocols and guidelines, and the service managers who have to ensure local service delivery reflects the whole-of-government outcomes. Thus policy coherence has to work not only across agencies, but across all levels of the system.

It can be expected that the demand for horizontal governance and collaboration will continue to grow. While vertical structures, incentives and accountabilities will persist, there is a challenge for government agencies to develop the leadership and management capabilities and accountabilities to ensure successful horizontal management (Lindquist 2010). Culture change and capacity building are likely to be required.

Policy coherence and joined-up thinking can be challenged when political and economic climates change. In an earlier phase of the political cycle, ie a new term of government, or in a fiscal expansionary period, policy innovation and pilot programs may be more easily pursued. Unless the new practices are embedded into systems, they would be more difficult to sustain when periods of retraction force government agencies to protect their pre-existing programs and strategies.

There is a need to understand better how to effect and secure intersectoral action for SDH, particularly HiAP. There are lessons to be learned internationally about how the public agenda for health is set, how policies are formulated, how HiAP is effective implemented and appropriately evaluated, and what policy interventions have been effective. The variety and effectiveness of governance actions, and their relationship to the variety and effectiveness of governance structures and processes, is at the core of what needs to be understood better.

The Cases

One of the advantages of a federalist system is that it allows for jurisdictions to experiment, thus creating the condition for policy learning and adaptation across the country. While a disadvantage of such a system is that it requires a complicated processes of coordination and policy alignment for any innovation to be scaled up nationally. Federalism also offers the opportunity for not doing 'one size fits all'. While all jurisdictional health authorities experience the challenge of demonstrating change in health outcomes within short electoral cycles, the variation in political terms also allow for different lengths and trajectories in experimentation and innovation.

The cases in this monograph represent a selection of current action by Australian governments to adopt an intersectoral approach to address social determinants of health. They demonstrate different approaches to joined-up policy making and action on social determinants. Indeed the emphases in the case studies vary – some are more focused on specific SDH, some are more concerned with health inequalities, and others are more concerned about making joined-up government work.   These are interrelated concepts and practices, but the foci of the cases reflect the current progress and concern of the particular jurisdiction.

These case studies point to different ways in which policies and programs are developed and implemented, showing the diverse pathways that are possible. The framework in place for HiAP in South Australia (SA) reflect a top-down approach, while the development of *A Healthy Tasmania* represents a combination of government-led and bottom-up community approaches for getting policy action initiated. How targeted programmatic actions based on intersectoral partnerships can address SDH are demonstrated in the Northern Territory (NT) and New South Wales (NSW) cases that address the impact of water supply and housing, respectively, on ATSI health. While a comprehensive coordinated national approach to address health inequality for ATSI peoples is demonstrated by the federal government's "Closing the Gap" initiative. Policy development through partnerships across government sectors and the community is illustrated by several cases, while embedding new policy models in a sustainable manner through legislative change is seen in the Victorian (VIC) case study.

Although there is a distinction made in the literature (Kickbusch 2010) between intersectoral action, healthy public policy, and health-in-all-policies, reflecting the shifts in thinking and practice internationally, these case studies fall into all three categories of approaches. What they share in

common is the action on social determinants of health, particularly with a view to addressing health inequities.

These cases concern policy development as well as policy implementation, though in varying stages of development. Their developmental pathways also reflect historical and contemporary contexts in those particular jurisdictions. Notable amongst these six case studies is the commitment to closing the gap in ATSI health, and this is both symbolically and practically important for Australia, given the inequitable health status of Aboriginal and Torres Straits Islander people and the impact of past policies and practices which have contributed to their historical social and economic disadvantage.

The Rio Political Declaration (WHO 2011) called for particular areas for action. These are all illustrated by these six case studies: governance for health, participation in policy making and implementation, role of the health sector to promote health and reduce health inequities, monitoring progress and increasing accountability.

Most of these cases are works-in-progress. Many of these cases are still in relatively early stages of implementation. Monitoring is just commencing for some of them, while evaluation has yet to be undertaken for most of them. The Victorian public health legislation case study, however, shows how long it takes to embed intersectoral action into governance framework and practice. Together, these case studies show how to move from idea for solving a problem to having the authorizing environment and to creating a sustainable enabling environment. Ultimately, having good evidence that joined-up government makes a tangible difference will be important not only for policy learning, but also for public accountability and enhancing community awareness.

Nonetheless, across these cases, some key themes also emerge. These include: the use of evidence, paying attention to the importance of generating co-benefits, the importance of a leadership team, the exercise of cross-party political commitment beyond electoral cycles, the availability of resources, the existence of tools for operationalizing policy concepts, the role played by networks, and a pragmatic focus on getting results. These themes need to be considered in the context of both historical trajectories as well as particular political junctures. They also point to the importance of ongoing networks and leaders, particularly in the context of policy contexts that can change quickly.

Consistent with international literature (National Collaborating Centre for Determinants of Health 2012), these case studies demonstrate that intersectoral action on SDH involves both the articulation of a strategy or intervention and a process for effective relationship management (for all phases of decision-making about policies and projects). They also reinforce both the need to take a longer term perspective in assessing possible health and social outcomes and the importance of taking an action learning approach in the short term to ensure the process stays on track and adapts to the changing environment.

Conclusions

Countries all share in the challenge of how to effectively act on social determinants of health to address persistent health and social inequalities. The complexity and wickedness of problems demand new approaches. Command and control and simple coordination strategies are unlikely to be effective, as no one institution, in or out of government has control of all the levers for change. A whole of government approach sets the framework, and complements, a whole of society approach.

The case studies presented here shows that there have been a variety of efforts in the Australian federation to adopt policy and programmatic interventions for action on social determinants of health. Intersectoral programmatic efforts have shown tangible results in delivering health improvement.   Partnerships and intersectoral governance take work to build and to sustain. Whole-of-government and whole-of-health sector strategy are promising, but networks within and beyond government are crucial, and the challenge is embedding these approaches in a sustainable way.

The Australian experiences suggest pragmatic incrementalism as the main approach, including both targeted programmatic response as well as the attempt to create an enabling environment through joined up governance and legislation action. Closing the health equity gap is possible if appropriate commitment, leadership, and implementation occur. The lesson from Australian experiences is to combine pragmatic action with planning for sustainability so that action on SDH can become embedded into existing systems. The ultimate test is to achieve sustained outcomes from implementing the "Closing the Gap" initiative for Aboriginal and Torres Strait Islander peoples.

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South Australian Health in All Policies initiative

> **Project title:** South Australian Health in All Policies initiative
>
> **Social determinants of health addressed:** Education, active transport, migration, water security, digital technology, urban development, mobility (drivers licensing), employment and sustainable regional development.
>
> **Agencies involved:** Whole of government. The initiative is jointly overseen by the South Australian Department of the Premier and Cabinet and the Department for Health and Ageing.
>
> **Does case study describe a policy or a project or change to service delivery?** Policy
>
> **Summary statement of case study:**
>
> The South Australian Health in All Policies initiative is an approach to working across government to better achieve public policy outcomes and simultaneously improve population health and wellbeing. Established in 2007, the successful implementation of Health in All Policies in South Australia has been supported by a high level mandate from central government, an overarching framework which is supportive of a diverse program of work, a commitment to work collaboratively and in partnership across agencies, and a strong evaluation process.
>
> **Key Points:**
>
> - Complex or 'wicked' policy problems have multiple causal factors, often beyond the scope of one agency or sector. Joined-up policy and intersectoral action across government is required to tackle these problems.
>
> - By incorporating the consideration of health impacts into the policy development processes of all sectors, a Health in All Policies approach allows government to address the determinants of health in a systematic manner while taking into account the benefit of improved population health for the goals of partner agencies.
>
> - By investing in building the knowledge and skills of the collective public policy workforce, increasing the capacity for research and evaluation, and mandating at the highest strategic level action on achieving improvements in population health and wellbeing, the ability of government to systematically address and respond to the social determinants of health is significantly improved.
>
> **Key contact and/or website:**
>
> For further information visit www.sahealth.sa.gov.au/healthinallpolicies

Introduction

As is the case for many other countries and jurisdictions, the South Australian health system is struggling with escalating health care costs, the growing burden of an ageing population and an increasing incidence of chronic disease. Addressing the escalating health budget is one of the pressing issues faced by the Government of South Australia. In 2012-13, $4.927 billion will be spent on health services in South Australia - 129% higher than in 2001-02 and almost a third of the

Government's total expenditure.[1] Growth in health expenditure at this rate is not sustainable and requires new approaches. Improving the health of the South Australian population and reducing the incidence of chronic disease will contribute to reduced health care expenditure.

Health and wellbeing is influenced by a range of social, economic, and environmental factors, known as the social determinants of health, which often sit outside the direct influence of the health sector. Actions to address complex, multi-faceted 'wicked problems' such as preventable chronic disease and health care expenditure require joined-up policy responses.

In South Australia, a whole-of-government framework, South Australia's Strategic Plan, seeks to enhance the state's prosperity, sustainability and quality of life for its citizens, and has been described as a blueprint for action on the social determinants of health.[2] Many of the targets contained in South Australia's Strategic Plan are important social determinants of health and action on the targets is likely to have positive health and wellbeing outcomes for the population, and contribute to longer term reduction in health care expenditure. The plan recognises the need for concerted and cooperative action across multiple sectors of South Australian society to achieve the targets. It was within this context that Professor Ilona Kickbusch, in her role as the 2007 Adelaide Thinker in Residence,[3] proposed that South Australia adopt a Health in All Policies approach and that this approach be applied to the government's strategic priorities and policy imperatives.

Health in All Policies is about promoting healthy public policy and is based on the understanding that health is not merely the product of health care activities, but is influenced by a wide range of social, economic, political, cultural and environmental determinants of health. The concept of Health in All Policies originated in Europe and has been applied, in various forms, in a number of countries. In South Australia, Health in All Policies has been adopted as an approach to working across government to better achieve public policy outcomes and simultaneously improve population health and wellbeing through joined-up policy development. The South Australian Health in All Policies approach utilises a model specific to the Government's organisational structure to address the government's overarching strategic objectives, including both South Australia's Strategic Plan and the recently released Seven Strategic Priorities. By incorporating a focus on population health into the policy development process of different agencies, the government is able to better address the social determinants of health in a systematic manner.

The South Australian Health in All Policies model seeks to build strong inter-sectoral relationships across government and facilitate policy work of mutual benefit to the health sector and the partnering sector (see Box 1 for example). A key feature of the approach is the 'Health Lens Analysis', a process through which the interactions and synergies between government policy and strategy, and the health and wellbeing of the population, are identified. The process utilises a range of methodologies (e.g. economic modelling, evidence reviews) to develop evidence-based recommendations for the policy area under consideration.

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[1] Government of South Australia. 2012. Health budget 2012-13. Government of South Australia, Adelaide.
[2] Kickbusch, I. 2007. Healthy societies: addressing 21st century health challenges. Government of South Australia, Adelaide.
[3] The Adelaide Thinker in Residence program, an initiative of the Government of South Australia, brings influential leaders and experts to South Australia to live in residence and meet and engage with key decision makers. At the conclusion of their residency, Thinkers provide a series of recommendations to the Premier for action. For further information visit http://www.thinkers.sa.gov.au/.

Importantly, the South Australian Health in All Policies model focuses on improving population health and wellbeing outcomes through action on the policies of other sectors that impact on the social determinants of health, rather than starting from a health policy focus. To date, the Health in All Policies approach has been applied to a range of policy areas of importance to South Australia including: water security, regional migrant settlement, broadband access and use, active transport, urban planning, determinants of obesity, education, sustainable regional development, and mobility (drivers' licensing).

Vision, Aims and Objectives

Vision

Public policy creates the social, economic and environmental conditions to promote population health, wellbeing and equity.

Aim

Improve the health and wellbeing of South Australians by strengthening cross-government action on the social determinants of health through a Health in All Policies approach to government priorities and public policy.

Objectives

- Support the implementation of the Health in All Policies approach systematically across government, through its application to South Australia's Strategic Plan targets and Seven Strategic Priorities

- Support the achievement of government strategic priorities and in doing so, health and wellbeing by working collaboratively across government, enabling effective policy partnerships

- Through the application of the Health Lens Analysis model and other methodologies, articulate the interactions between the social determinants of health and public policy, and identify evidence-based policy opportunities that are supportive of health and wellbeing

- Ensure the sustainability and applicability of the Health in All Policies approach and underpinning philosophies by building and maintaining capacity across all sectors, including health

- Increase the credibility and rigour of the South Australian Health in All Policies model through appropriate research and evaluation

- Benchmark the South Australian Health in All Policies approach with comparable national and international approaches to further develop the efficacy and applicability of the model.

Underpinning principles

The Government of South Australia recognises that a new form of governance for health is needed where there is joined-up leadership within governments, across all sectors and between levels of government.[4] The Adelaide Statement on Health in All Policies[5] outlines a new role for the health

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[4] World Health Organization & Government of South Australia. 2010. Adelaide Statement on Health in All Policies, Government of South Australia, Adelaide.

sector and for government in resolving complex policy problems. Action on the social determinants of health requires the health sector to contribute and facilitate joined-up policy making, rather than seeking to lead policy making in areas where the policy levers are outside the remit of the health sector.

The underpinning principles of South Australia's Health in All Policies initiative are informed by key drivers described in the Adelaide Statement on Health in All Policies, which are context specific and include:

- creating strong alliances and partnerships that recognise mutual interests, and share targets

- building a whole of government commitment by engaging the head of government, cabinet and administrative leadership

- developing strong high level policy processes

- embedding responsibilities into governments' overall strategies, goals and targets

- ensuring joint decision making and accountability for outcomes

- enabling openness and full consultative approaches to encourage stakeholder endorsement and advocacy

- encouraging experimentation and innovation to find new models that integrate social, economic and environmental goals

- pooling intellectual resources, integrating research and sharing wisdom from the field

- providing feedback mechanisms so that progress is evaluated and monitored at the highest level.

Governance and Reporting Structures

The South Australian Health in All Policies initiative is jointly overseen by the Department of the Premier and Cabinet and the Department for Health and Ageing. Central government oversight for Health in All Policies operates through the Seven Strategic Priorities for relevant matters or through the Senior Management Council, a group comprised of the Chief Executives of all government departments, and finally Cabinet itself.

The Seven Strategic Priorities are areas of activity the government has chosen to focus on over the next years. The priorities complement and support progress towards the longer term goals outlined in South Australia's Strategic Plan. The Seven Strategic Priorities are:

- Creating a vibrant city

- Safe communities, healthy neighbourhoods

- An affordable place to live

- Every chance for every child

- Growing advanced manufacturing

[5] World Health Organization & Government of South Australia. 2010. Adelaide Statement on Health in All Policies, Government of South Australia, Adelaide.

- Realising the benefits of the resources boom for all South Australians

- Premium food and wine from our clean environment.

Cabinet Taskforces are leading the work on each priority area and have established key targets against which progress will be monitored. Under the taskforce, each strategic priority has a Senior Officers Group which has responsibility for progressing work related to the priority. The Senior Officers groups are comprised of high level executives from government agencies with a policy interest or core business related to the priorities.

In 2012, the Health in All Policies unit undertook a Health Lens Analysis across the seven strategic priorities to identify the health and wellbeing connections to each of the priority areas, and through this process, new areas of work for future Health Lens Analyses have been identified. Under existing governance arrangements, it is expected that the Senior Officers Groups will identify an appropriate policy focus for each Health Lens Analysis, approve project proposals and endorse the final project recommendations.

Central government leadership has been essential to the success of Health in All Policies in South Australia and provides a clear statement of the government's commitment to the initiative. It also provides a mandate to work across government, has provided partner agencies with the impetus and motivation to engage with Health in All Policies. In addition to the horizontal governance structure, the South Australian Health in All Policies model utilises the traditional vertical decision making structures of individual government agencies in project approval processes (Figure 1).
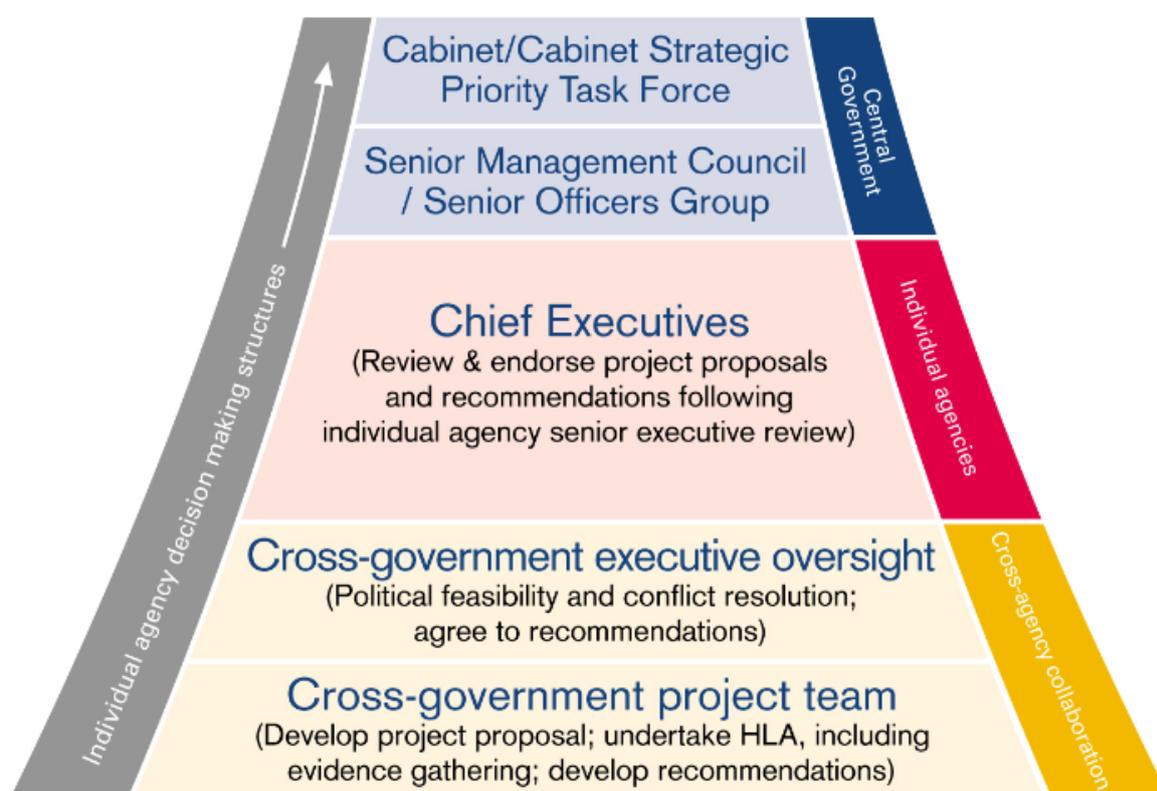
Figure 1. Health in All Policies horizontal and vertical governance

Vertical governance structures are an important part of the governance process as they maintain the authority and policy responsibility of individual department Chief Executives and executive leadership teams, and ensure that when policy recommendations are made, there is a high level understanding and commitment to their implementation.

Health Lens Analysis

The Health Lens Analysis model is a key feature of the South Australian Health in All Policies approach. The aim of a Health Lens Analysis is to identify key interactions and synergies between targets in South Australia's Strategic Plan, the Seven Strategic Priorities, government policies and strategies, and the health and wellbeing of the population. Of critical importance is the emphasis placed on both achieving the goals and objectives of the partner agencies and on improving health and wellbeing outcomes and reducing inequities. The Health Lens Analysis seeks to develop policy outcomes for all agencies involved, in particular the lead agency. To this end, reciprocal outcomes for participating agencies are sought in all cases.

The Health Lens Analysis involves five stages:

Engage*
- Develop relationship with partner agencies, including establishing project specific governance structures

- Identify and clarify contextual issues

- Negotiate and agree on the policy focus

- Form a project team and identify resources

- Plan work and determine processes

- Establish evaluation criteria

*Although this stage typically occurs at the beginning of the Health Lens Analysis, engagement continues throughout all of the projects.

Gather evidence
- Undertake evidence gathering

- Joint exploration and discussion of the policy issue

- Reconciliation of differing perspectives

- Shape conclusions and policy recommendations

Generate

- Produce project report and final recommendations

- Explore implications of the recommendations (budgetary or otherwise)

- Refine recommendations so that they are achievable

Navigate

- Navigate final report and recommendations through agencies' decision making processes

- Executive sign off from health and partner agencies

- Report to Senior Officers Group/Senior Management Council

Evaluate

- Evaluate project processes, impact and outcome

The relationship between the governance mechanisms for the South Australian Health in All Policies initiative and the Health Lens Analysis process is described in Figure 2.
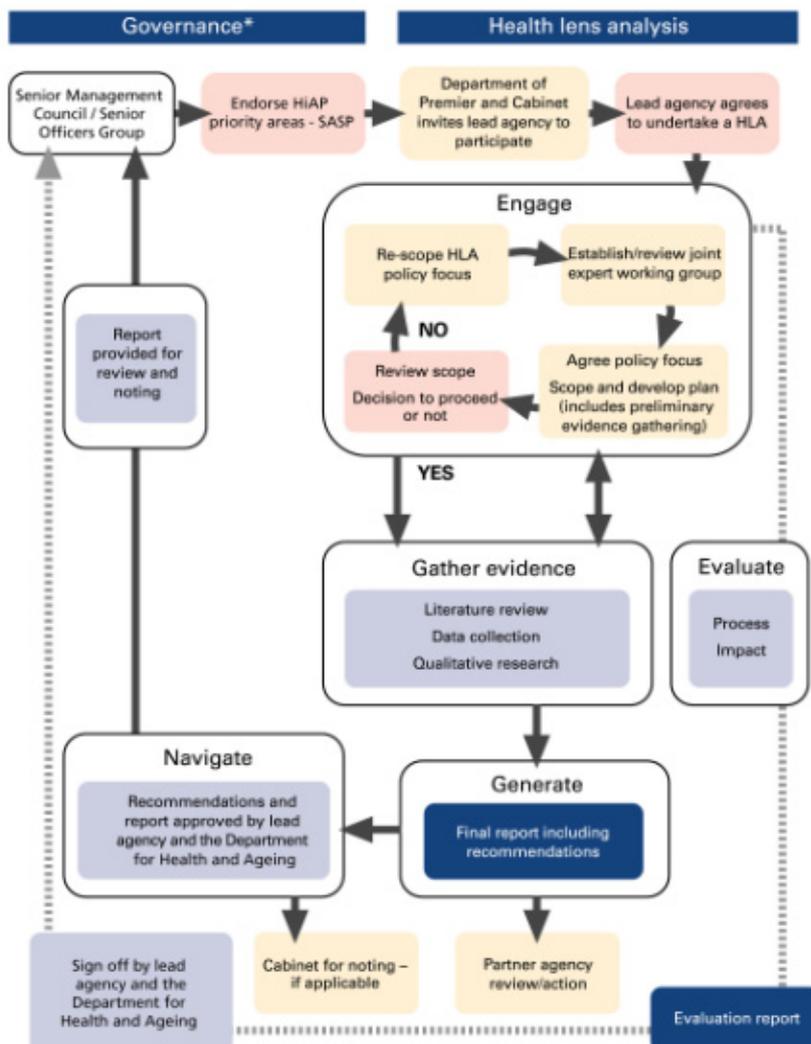

Figure 2. Relationship between governance and the Health Lens Analysis process in South Australia's Health in All Policies initiative.

Application

Since 2007, the Health Lens Analysis process has been applied to a wide range of social determinants of health including active transport, migration, water security, digital technology, urban development, mobility (drivers licensing), employment and sustainable regional development. Box 1 describes a current Health Lens Analysis project which is focused on education – Parental Engagement with Literacy. There is a strong link between positive education outcomes and long term health outcomes, including increased life expectancy and reduced levels of chronic disease. The aim of the project was to raise parental engagement with literacy to improve literacy outcomes for children in the early years of schooling, and ultimately improve their health, with a particular focus on low socio-economic families. Further information on South Australia's Health Lens Analysis projects can be found at www.sahealth.sa.gov.au/healthinallpolicies.

Box 1. Health Lens Analysis Case Study – Family Engagement with Literacy

The *Family Engagement with Literacy* project is a partnership between the South Australian Department of Education and Child Development (DECD) and the Department of Health and Ageing (DHA). The Executive Committee of Cabinet Chief Executives Group, a senior executive committee which formerly provided oversight of the Health in All Policies, endorsed education and early life as one of the priority areas for Health in All Policies and invited DECD to participate in a Health in All Policies Health Lens Analysis project. The importance of literacy is reflected by its inclusion in South Australia's Strategic Plan as a target, and the project proposal was endorsed by the Chief Executives of the two agencies in July 2010. The objective of the project has been to investigate how to better engage families in co-creating a literacy rich environment for children at home and school, with a focus on low socio-economic areas.

Engage

Engagement occurred through-out the project, through both the formal governance structures outlined above, as well as through informal mechanisms. A significant proportion of time was allocated to ongoing engagement. Staff from DHA and DECD (central office) collaborated for several months to identify and scope the focus of the project, before developing an agreed project proposal for sign off. Once endorsement of the project proposal had been received, the formal governance and reporting structures to oversee the project were established.

The governance and reporting structures for the Family Engagement with Literacy project were complex, partly due to the decentralised nature of the education system and the need to engage with each level of the system – senior executives, regional staff, teachers and parents. The following structures were established:

- A **Steering Committee** with representatives from the Health in All Policies unit DHA, DECD Western Regional Office, DECD Central Office oversaw the direction of project, made key decisions and ensured the policy implications of the project were relevant and appropriate.
- The **Western Adelaide Regional Steering Group** included HiAP, DHA staff, Regional office staff and the principals of the four participating schools. This group was key in maintaining connections with the governance of the schools, and ensuring relevance to the region.
- The **4Schools Group** included staff from the Health in All Policies unit DHA, Parental Engagement Project Manager, principals and teachers from the four schools. This group was predominately an information exchange group, but also provided direction for the project, as teachers are key drivers of policy direction at the school level, and thus up to the DECD Central Office. This group was also key in providing school based contextual information to the project.

Box 1. Health Lens Analysis Case Study – Parental Engagement in Literacy Rich Environments

- o The 4Schools Group included about 20 teachers, and met once a term. These meetings provided an opportunity for teachers and principals to share learning's from past and current approaches and programs, and to consider how the research emerging from the project could be incorporated into their practice.
- **Project Working Group** included staff from the Health in All Policies unit DHA staff and the Parental Engagement Project Manager. This group met regularly to progress the work of the project.

- A **Parental Engagement Project Manager** was funded through DECD, National Partnership Agreement with top up funds from DHA. DHA also provided funding support for the research and evaluation components.

The formal governance mechanises described above proved effective in maintaining the interest and ownership of the project by the different levels of education and health. They also allowed engagement and information exchange with non-government organisations such as the Smith Family, and an increased understanding of the role of the non-government organisations in supporting this area of work.

Gather evidence

1. Literature review

A broad literature review was undertaken by DECD which showed that improved literacy outcomes for children in the early years of schooling can be achieved through raising parental engagement with literacy at home. Further review of the literature was undertaken by DHA to provide context around literacy and the role of parents, and outline examples of programs (or elements of various programs) which had been found to be successful in improving parental engagement. These reviews helped scope the project and provide direction for the qualitative research.

2. Schools
Under the auspices of the Low Socio-Economic Status School Communities National Partnership, the four schools involved in the project worked to identify and apply practices that lead to richer literacy environments in learners' homes. This included building stronger family -school partnerships and building capacity in parents and caregivers to support the learner at home. The Project Manager, Parental Engagement coordinated activities between the schools.

The project engaged with teachers in Reception to Year 2. Initial consultations with the teachers sought to gauge staff's perspective of their role and requirements in supporting parents to develop literary rich home environments, as well as identify examples of best practice approaches to support parental engagement. The teachers were also involved in the development of the qualitative research described below.

3. Focus groups
Developing an understanding of the barriers and facilitators to engagement with literacy from the parents' perspective was key to recommendations in this area. DHA and DECD commissioned the South Australian Community Health Research Unit, Flinders University of South Australia, to undertake focus groups with parents and caregivers. Ten focus group discussions were held with 66 parents and grandparents between the end of July and mid-September 2011. Groups represented parent diversity across the 4 schools: 3 mainstream English-speaking groups; 2 Aboriginal English-speaking groups; 5 groups from specific cultural backgrounds where parents had ESL or no English (Indian, Serbian, Somali, Chinese, and a mixed New Arrivals group with parents from Sri Lanka, India/Pakistan, Vietnam, Ethiopia, and West Africa).

Box 1. Health Lens Analysis Case Study – Parental Engagement in Literacy Rich Environments

The focus groups sought to:

- establish what parents believe constitutes literacy engagement with children, and what they see their role (if any) as compared with the role of schools and teachers
- identify strategies which parents feel would assist then to develop or increase their skills, resources and capabilities to provide a literacy rich home environment for their children
- identify parents' views about how easy or difficult it is for them to approach, communicate with, and engage with their children's school, and whether particular aspects of the school or of DECD and other government structures support or undermine this, or could better support them.

4. Trialling initiatives
Drawing on research findings and professional wisdom, each of the four schools trialled initiatives to support parental engagement. Case studies of their experiences have been documented to provide resources for other schools to use.

Generate
The key outcomes from the evidence gathering stage have been the development of a working model of "Family Engagement in Literacy" and recommendations aimed at the school, region and systems level.

The "Family Engagement in Literacy" model has guided the generation of relevant school-based resources. The model describes the three domains of:
- Resources: developing and providing appropriate literacy resources that families can then use at home to create a literacy rich environment
- Knowledge and Strategies: running activities that raise parents/carers' awareness of literacy learning and strategies to support their child's literacy development
- Communication and Confidence: strengthening the parent/carers' confidence to engage with teachers about their child's literacy development while opening lines of communication between school and the home.

Some practical examples of the work that has been carried out by the participating schools in the context of this model include the:
- Creation of "literacy show bags" that contain a range of engaging literacy activities that can be carried out at home and are complete with instructions to parents/carers about how to support the activities.
- Development of a DVD resource that contains a range of literacy related materials that can be used at home but which relate to the programs being carried out at the school level. These resources have been converted into different languages to raise levels of access.
- Family awareness sessions where parents/carers are invited into their child's classroom at the end of a day so that for 30 minutes the teacher can explain a particular writing task to the parents/carers and how they support their child at home.
- Holding family activities on weekends (such as gardening) where appropriate information about literacy activities can be explained to parents who are often reluctant to attend more formal sessions.
- The development of readers that can be taken home but are accompanied by a recording of someone reading the reader so that the reading is modelled for children and the parents.

Parental feedback about the quality and impact of these materials has been overwhelmingly positive, and has had a clear impact on the levels of literacy engagement for the children and the parents.

The Parental Engagement project is in process of finalising policy recommendations which frame areas of action at the school, region and systems level.

Monitoring and Evaluation

Monitoring and evaluation of Health Lens Analysis projects is built into the South Australian Health in All Policies model. Each Health Lens Analysis project includes a commitment by the Department for Health and Ageing and the project partners to undertake a joint evaluation of the project. Process and impact evaluation is undertaken by Southgate Institute, Flinders University of South Australia.

In 2011, Flinders University of South Australia was awarded a National Health and Medical Research Council grant to conduct an overall evaluation of the South Australian Health in All Policies initiative. The evaluation of the initiative is currently underway and is due to be completed in 2016.

Outcomes

To date, five of the Health Lens Analysis projects undertaken by the Department for Health and Ageing have been evaluated. The adoption of recommendations arising out of the projects (e.g. the development of a design guidance document) is just one part of the outcomes examined in the project evaluations. Less tangible outcomes, which are more difficult to measure and track over time, have also been identified and typically relate to relationship building and knowledge transfer between the project group members. Common themes identified in the evaluations have included:

- Changes in policy directions which impact on the social determinants of health and that are likely to contribute to positive, long term health and wellbeing outcomes

- Greater understanding and stronger partnerships between health and partner agencies

- Increased understanding by policy makers of the impact of their work on population health and health equity

- Development and dissemination of policy relevant research

- A willingness to use the Health Lens Analysis process and adopt Health in All Policies philosophy in future work

- Conceptual learning (redefining goals, problem definitions and strategies) and social learning (dialogue and interaction between stakeholders) for all involved.

Reflections on South Australia's Health in All Policies initiative

Establishment of Health in All Policies in South Australia

There were a number of opportunities which coincided to create the political environment and will within the Government of South Australia to adopt the Health in All Policies approach. Since South Australia's Strategic Plan was first implemented in 2004, the Government of South Australia has maintained a strong commitment to achieving the targets outlined in the plan. The targets included in the plan mirror the social determinants of health covering issues related to work, employment, education, food, transport, housing environment, early life and social support, and it is recognised that concerted and cooperative action across multiple sectors of South Australian society is required to achieve them.

In 2007 Professor Ilona Kickbusch, in her role as Adelaide Thinker in Residence, recognised the opportunity to use a Health in All Policies approach to explore the interconnections between the plan targets and to identify opportunities for joined up government. Linking Health in All Policies with the plan provided the opportunity to establish Health in All Policies as a whole of government concern, which has been a missing link in previous attempts at joined-up policy approaches.

In addition to the political environment and the role of Professor Kickbusch as a catalyst for change, the establishment of Health in All Policies in South Australia benefited from the State's strong history of social policy and a network of skilled, committed health policy practitioners and academics. This network acted as the catalyst to bring Professor Kickbusch to Adelaide as a Thinker in Residence and had a critical role in pursuing the opportunities presented by, and the recommendations arising out of, the residency.

Implementation of Health in All Policies in South Australia

From the very beginning of South Australia's Health in All Policies initiative, engagement with central government has been critical, both in terms of providing a high level mandate and direction as to the policy focus of the work. By linking Health in All Policies to the Government of South Australia's two guiding frameworks, South Australia's Strategic Plan and the Seven Strategic Priorities, this ensures the initiative is responsive to the links between economic development, productivity, and health and wellbeing. In addition, it also provides an impetus for agencies to engage with the Department for Health and Ageing in the Health Lens Analysis projects. Each agency Chief Executive must report to the Cabinet on the achievement of targets allocated to their department and Health in All Policies offers a framework through which activities to assist in achieving the targets can be progressed.

Moving the health agenda so that it can examine the core business of other agencies has also been critical to the successful implementation of Health in All Policies in South Australia. Health and other agencies are brought together early in the policy development cycle and it is this early engagement

which contributes to a sense of shared ownership of both the process and the final product, facilitating engagement of all sectors and the implementation of intersectoral actions.

Challenges

Whilst the evaluation of South Australia's Health in All Policies Health Lens Analysis model has shown that it is successful in facilitating cross-government policy development, a number of challenges (both current and future) have been identified. These include:

- Implementing Health Lens Analysis project recommendations in a changing and dynamic political environment

- Capturing the less tangible outcomes of the Health Lens Analysis project, particularly in relation to long term changes in the policy culture in agencies outside of health

- Ensuring projects are flexible and responsive enough to accommodate changes in policy priorities and the political environment

- The disjuncture between policy development, program implementation and service delivery. It is well recognised that it can be difficult to adopt even the best policies at the program and service delivery levels, and South Australia's Health in All Policies initiative must continue to look for ways to address this ongoing challenge

- Encouraging the uptake of the Health in All Policies philosophy and processes across the health sector

- The inclusion of community views in policy development. This is currently addressed through the use of qualitative research as part of the Health Lens Analysis process however further work is required to ensure community views are fully accounted for and acknowledged in the work.

Next steps

In recognising the challenges associated with implementing Health in All Policies in South Australia, the next steps for the initiative include building the capacity of state and local government, and other organisations, to apply the Health in All Policies philosophy. Specific strategies to build the capacity of the health sector for the development of healthy public policy will also be developed.

In addition to the current work of the Health in All Policies unit, the release of the South Australian Public Health Act 2011[6] provides future opportunities to build capacity for Health in All Policies. The South Australian Public Health Act 2011 provides a legislative basis for state and local government to implement a Health in All Policies approach and improve cross-sectoral action through public health planning provisions. Under the Act, the Minister for Health and Ageing must prepare a State Public Health Plan that sets out a framework for action to protect and improve health and wellbeing of South Australians. The plan incorporates the Health in All Policies approach and recognises the need to work collaboratively with other agencies to help them achieve their goals in ways that incorporate health considerations. Each local government is required to develop a public health plan which has

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[6] Government of South Australia. 2011. South Australian Public Health Act. Government of South Australia, Adelaide.

regard to the state plan and outlines actions to protect and promote the health of their local communities, recognising the influence of social determinants of health on health and wellbeing.

Conclusions

The Government of South Australia's implementation of Health in All Policies is a significant new development in the applied use of research evidence on determinants of health, and a first for Australia. The success of the initiative has rested on a number of key drivers including:

- Partnering with government departments on their policy imperatives to support the development of healthy public policy

- High-level mandate from central government

- Leveraging from existing government decision making structures

- Jointly generating evidence based solutions with project partners

- Integrating qualitative and quantitative social science methodologies to identify solutions for complex, "wicked" policy issues.

The South Australian Health in All Policies initiative has demonstrated its value as an approach to collaborative policy development. Health in All Policies also provides a framework for meeting the needs of sectors outside of health as well as long term population health and wellbeing goals, reflecting one of the key underpinning philosophies of the initiative, reciprocity. Cross sector collaboration and partnerships have been recognised as important system building strategies, and mechanisms to support and systematise these practices across state and local government will help to ensure the ongoing action on social determinants of health and improve the health and wellbeing of the South Australian population.

Project title: Strong Teeth, Healthy Bodies – A Partnership Between Industry, Community and the Department of Health

Social determinants of health addressed: The social determinants addressed in this project include; Early Years, Housing in the wider context in terms of accessing health infrastructure, Food Security in terms of access to safe and healthy water supplies, Health Literacy and Access to Health Services.

Agencies involved: Power Water Corporation (PWC), Department of Housing, Local Government & Regional Services, Department of Health (DoH) – Oral Health Services and Environmental Health, Andilyakwa Land Council (ALC)on Groote Eylandt

Does case study describe a policy or a project or change to service delivery? Project resulting in a change to utilities service delivery.

Summary statement describing key strategy and target audience of case study.

Strong Teeth and Healthy Bodies is a partnership between PWC and DoH to extend water fluoridation to five remote communities in the Northern Territory. Increasing access to fluoridated water is a key public health intervention to improve the health and wellbeing of people living in remote communities by reducing oral disease. This is a strong example of government working together with local Indigenous organisations to enhance the health of community members.

Key contact and/or website:

For further information visit
http://www.health.nt.gov.au/Oral_Health/Water_Fluoridation/index.aspx

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Introduction

Adding fluoride to the drinking water to achieve optimum levels is one of the top ten public health initiatives of the 20th Century and has been carried out in Darwin and Katherine for over 30 years. Approximately 80% of NT Indigenous children live in remote communities and the current rates of dental decay for these children are between two and five times those of non-Indigenous children. A key contributing factor to these poor oral health outcomes is correlated to the level of fluoride in drinking water. Fluoride can repair damage before it becomes permanent. A constant supply of low level fluoride in the mouth is best for this. In this way, fluoride in the water acts like a constant 'repair kit' for teeth.

Strong Teeth, Healthy Bodies was a partnership project between Power Water Corporation and the Northern Territory Department of Health to extend water fluoridation to five remote communities. Increasing access to fluoridated water has been shown internationally to be effective in preventing tooth decay and is a key public health intervention for remote Indigenous communities, which currently experience high rates of dental caries. The Strong Teeth, Healthy Bodies project will

improve the health and wellbeing of people living in remote communities by reducing the burden or oral disease and improving their oral health status.

The Northern Territory is equivalent in size to France, Italy and Spain combined. Darwin is the capital city of the Northern Territory, with regional centres Katherine, Gove, Tennant Creek and Alice Springs. There are 71 remote Aboriginal communities; these communities can range in size from only a couple of hundred people to 3000 people. Within the Aboriginal communities in the NT, there are wide regional differences and distinctions in language, culture, social structures, politics, environmental conditions, financial standing, contact history and community infrastructure. All of these factors impact on the community health and well-being.

All of the remote communities that were involved in the Strong Teeth, Healthy Bodies project are in the most disadvantaged category under the Socio-Economic Indexes for Australia (SEIFA). This project has contributed to increasing equitable access to water fluoridation across the NT population.

The public water supplies of Top End communities of the Northern Territory have low levels of naturally occurring fluoride; while communities in Central Australia south of Elliott have higher levels of natural fluoride present in their drinking water supply. Darwin's water supply was fluoridated in 1972 and Katherine's supply is also fluoridated.

Public water supplies south of Elliott have naturally occurring fluoride at levels in the water that assist to prevent dental decay, so this region does not need fluoride added to the water. Darwin, Katherine and Gove currently have fluoridation plants.

An enabling factor to the Strong Teeth, Healthy Bodies project progressing was that PWC already were undertaking work to provide safe community drinking water supplies in accordance with the Australian Drinking Water Guidelines 2004 (ADWG). The ADWG are intended to provide a framework for good management of drinking water supplies across Australia that will ensure safety at point of use. Power and Water utilises the ADWG framework and works closely with the Environmental Health Branch of the Department of Health to continually improve the quality of drinking water in the NT.

Historically, finding capital funding for water fluoridation has been a key barrier to implementation and was overcome in the project by including the project as part of other capital investment through the National Partnership Agreement for Remote Indigenous Housing (NPARIH) and through contributions by the Andilyakwa Land Council (ALC) & Groote Eylandt, Bickerton Island Enterprises (GEBIE) for the delivery of systems on Groote Island. The integration of the project into existing capital investment maximises cost efficiencies and it is unique to have a local organisation funding infrastructure investment.

The drinking water supply in each of the 5 project sites was already disinfected; however, the new treatment process provides a more efficient disinfection system. Water Chlorination is the preferred method of disinfection and ensures clean, good quality water from the tank to the household tap. This will ensure that the right amount of chlorine is added to keep the water clean and free from micro-organisms (bugs).

Fluoridation of the drinking water in the five of communities of Maningrida, Wadeye, Nguiu, Angurugu and Umbakumba has now been achieved in conjunction with the delivery of significant capital investment in the water supply systems to maximise cost efficiencies.

The Strong Teeth, Healthy Bodies project adds fluoride to the drinking water to increase the concentration to optimum levels. Optimum fluoride levels in the Northern Territory are outlined in the table below. The optimal fluoride concentration for water fluoridation is dependent on the average maximum air temperature.

Overtime this will reduce the prevalence of dental caries across the remote population and contribute to closing the gap between Indigenous health outcomes and those of the non-Indigenous population. This approach of water fluoridation is widely used and recognised as one of the top ten public health interventions of the 20th Century, with the most pronounced effects demonstrated amongst those who are most disadvantaged.

The project is a key action identified within the Healthy Mouths Healthy Lives: Australia's National Oral Health Plan 2004-2013 and is in accordance with the Department of Health (DoH) position statement on 'The Use of Fluorides in the Northern Territory' released in 2010. The DoH position statement recommends that water fluoridation be extended to all people living in communities with a fixed population of 600 or more, where naturally occurring fluoride is less than 0.5mg/L. This project also contributes to the implementation of the Northern Territory Oral Health Promotion Plan (NTOHPP) 2011-15.

Vision, Aims and Objectives

The aim of this project is to facilitate improvement in the oral health status of the NT population with a particular emphasis on Aboriginal and Torres Strait Islander people and other disadvantaged groups.

Goal:
This project extended water fluoridation to 5 remote communities in top end NT that had water fluoridation identified in their local implementation plans, developed by the local community, the project will also encourage greater consumption of tap water.

Objective1:
Ensure technical delivery of a standard water fluoridation system in all 5 sites by the end of 2012.

Objective 2:
Develop a communication strategy about the delivery of water fluoridation and the health benefits of fluoride being added to the water prior to installation of the plants.

Case Study Description

The Strong Teeth, Healthy Bodies project delivers long-term benefits across the remote population, especially children, by improving oral health outcomes and contributing to closing the gap on Indigenous disadvantage. The cost benefit analysis of fluoridating the larger remote community water supplies has been demonstrated to lead to significant cost savings with a break-even point within three years (Gray N, Beirne K, Zhao Y, Guthridge S. 2008). This analysis did not quantify the indirect benefits of caries reduction and is likely to have underestimated the true benefits to be gained from water fluoridation. Therefore, overtime the project will achieve substantial cost efficiencies to improve oral health outcomes in the five remote communities.

The implementation of the fluoridation systems has been made in conjunction with upgrades to the chlorination systems and the delivery of significant water supply investment to maximise cost efficiencies. The upgrade to the chlorination systems was critical to the project as increasing the

reliability and efficiency of disinfection, which protects public health by reducing exposure to disease causing micro-organisms.

The fluoridation systems will be operated and maintained by PWC for at least 30 years and provide long-term benefits to remote community health outcomes.

As part of the partnership Oral Health coordinated a consultation process for the Strong Teeth, Healthy Bodies project with technical support by Power Water Corporation. The leadership by Oral Health provided a single interface for members of the community and stakeholders to discuss the project and clearly reinforced that the initiative will improve health outcomes.

The consultation process involved the use of innovative health communication strategies to improve the health literacy of the community in regards to water fluoridation, chlorination and the importance of improving oral health. They were targeted at community members, organisations and health professionals. Talking posters with information about water fluoridation and chlorination have been developed in six local languages across the five communities and a two-page flyer and a Frequently Asked Questions (FAQ) booklet have been developed to provide more detailed information for key stakeholders so they could also disseminate information and answer queries about the project. These materials were also used to liaise and discuss the project at various meetings and in particular engage with the Local Reference Groups in each community.

This project capitalised on engaging communities through the Local Reference Groups. These groups had already identified water fluoridation as an area for action under Local Implementation Plans. The project team utilised innovative health communication methods, ensuring information was available in local language to increase health literacy about water fluoridation and disinfection. Face to face meetings and information sessions were held in each site to ensure that community members could ask questions of both DoH and PWC staff.

Communication material developed is available on the Department of Health website: http://www.health.nt.gov.au/Oral_Health/Water_Fluoridation/index.aspx

Governance and Reporting Structures

PWC are responsible for the ongoing operation of the fluoridation systems, with the day to day operation carried out by local Essential Services Officers (ESOs). The current ESOs have been trained in the operation of the systems, providing additional training opportunities and increased responsibilities for local ESOs. The modern fluoridation systems operate automatically and have a number of safety features that ensure that ESOs are protected and the community will consistently receive optimal fluoride levels. The results of the operational monitoring will be integrated into existing regulatory reporting relationships between DoH, in particular through the Environmental Health Branch and PWC to ensure the long-term sustainability of the project.

Regulatory/ monitoring in terms of fluoride, has been incorporated in the existing monitoring protocol between DoH and PWC. Reporting during the project with all community reference groups, in particular, about the communication and resources as well as progress updates on the treatment plants.

Monitoring the operation of the fluoridation systems has been integrated into existing regulator reporting relationships between Department of Health and Power Water Corporation to ensure the long-term sustainability of the project.

Importantly, DoH, through Oral Health Services, is collecting additional child oral health information in the five communities where water fluoridation has been introduced. This will provide base-line oral health status data, which can be analysed in 5 years to ascertain health gains made since the introduction of water fluoridation.

Monitoring and Evaluation

In July, 2004 the Australian Health Ministers' Conference endorsed Healthy Mouths, Healthy Lives: Australia's National Oral Health Plan 2004-13. This plan established a framework for improving the oral health and, in turn, the general health of all Australians. The first Action Area identified in the National Plan is the promotion of oral health across the population. An important component of this plan was the aim to fluoridate all communities over the population of 1000 where there is no access to naturally fluoridation water. As part of an ongoing monitoring process of this plan, DoH Oral Health Services have provided updates in regards to developments and progress of the extension of water fluoridation.

This project also contributes to the achievement of actions within the NT Oral Health Promotion Plan 2011-15. http://www.health.nt.gov.au/Oral_Health/Oral_Health_Promotion/index.aspx

PWC and DoH are jointly evaluating the partnership against the achievement of the objectives of the Strong Teeth, Healthy Bodies project. The evaluation includes the communication strategy, the oral health outcomes and operation and maintenance of the fluoridation systems.

Process Evaluation

This project was able to reach all of the intended target groups. The intention of the communication component of the program was to meet with Local Reference Groups to provide information about water fluoridation and disinfection as well as answer any questions they may have. Where possible, in-services were carried out with health staff at local community health centres, information was also provided for those staff electronically.

The strategies outlined in the communication component of the project have enabled communications to be consistent and streamlined. A mixture of hard copy resources, talking posters, improved website information and face to face information sessions has ensured information was shared with as many people as possible throughout the project.

This project has been further supported through the use of the planning and evaluation template and framework outlined in the Quality Improvement Program Planning System (QIPPS). This web-based system is used throughout NT Department of Health by several program areas and also enables outside agencies to access the same document. The key personnel in this project utilised QIPPS to plan the project and document the evaluation findings, making collaboration easier.

Impact Evaluation

There were a number of pieces of work that have assisted the Strong Teeth, Healthy Bodies project to proceed. These include; the Cost Benefit Analysis completed by Health Gains Planning, DoH in 2008, the Fluoridation of Remote Communities Water Supply, Options for Development and Assessment presented by Hunter Water Australia in 2008 and the DoH Position Statement on the 'Use of Fluorides in the Northern Territory' published in 2010.

This project is an example of working across Government and sectors in a positive and supportive way. The partnership built on existing strengths and responsibilities of each organisation. This facilitated open communication for the life of the project and beyond. The project and partnership also highlighted the stake that a number of organisations, community groups and industry have in safe and healthy water supplies.

The communication strategy about the Strong Teeth, Healthy Bodies project has been led by Oral Health Services, DoH. Talking posters were designed, with information about the health benefits of water fluoridation and disinfection recorded in 6 local languages. This initiative is an innovative way of ensuring health communication best practice, these strategies have also contribute to addressing key contributing factors identified in the needs assessment at the beginning of this project.

Has the project increased the capacity of the community and/or organisation to respond to this or future health issues?

Throughout the life of this project, community members and in particular the members of the Local Reference Groups capacity to access oral health information has improved. Each of the 5 sites identified for this project had an interest in improving the oral health of their community and had already identified it within the Local Implementation Plan.

Have there been any unintended outcomes? What was their impact?

A positive unintended outcome of this project was that Nguiu community became more engaged with oral health promotion generally. The Government Business Manager and his team requested additional resources for school age children and planned sessions at the school using the colouring in resources supplied by Oral Health Services. This was a direct outcome of the face to face information session conducted in Nguiu in October 2011.

During the consultation process in Maningrida, the local community leaders identified that they had a spiritual connection to their water supply and its origin because it came from under the ground. This lead to a greater awareness on the part of the project team on the needs of the community to understand that their water supply was not being changed under the ground, but all water treatments would be carried out above ground. Additional consultation and community education was carried out in Maningrida to ensure that the community was comfortable and understood the benefits of the intervention and that their spiritual connection to the water supply was not jeopardised.

Outcomes

Water fluoridation ensures that all people who have access to tap water have access to the health benefit of water fluoridation. The initial goal of this project was to enable access to fluoridated water supplies for 5 remote communities in the Top End of the NT. This was achieved within the time frames established for the project.

As the extension of water fluoridation to communities of 1000 or more residents is a target within the National Oral Health Plan 2004-13, progress reports on national targets will include the NT updates. Base line data on Child Oral Health in the Northern Territory will be collated this year from Decayed, Missing Filled Teeth (dmft/DMFT) data in Titanium, over the next 5 years. Department of Health will use this data to evaluate preventive interventions including water fluoridation. Health status data will be analysed in 5 years to ascertain health gains made since the introduction of water fluoridation.

The reduction of oral health disease will be able to be validated in the coming years. However, the evidence for the efficacy of fluoridation on the reduction of decay within populations is extensive.

Engagement and language:

The community, community groups and government and non-government organisations all benefited from the integrated approach and the development of resources in community appropriate languages. The process utilised and the partnership established will be able to be transferable to other projects. The trust created within the community by working together will be utilised by each organisation in other projects.

Working relationship across sector and government:

The learning from the relationship across sector and government, when there are clear demarcations about roles and responsibilities and clearly defined outcomes can be transferred to other projects that need cross sector involvement, especially in the NT where many health outcomes are determined by actions and policies in sectors outside the health sector.

Cost effectiveness:

This project has been carried out with reference to the Cost Benefit Analysis published in 2008.

The partnership approach used in this project built on existing relationships between organisation and involved cross Government and cross sector collaboration. The success of the relationship is testament to the utilisation of clear roles, responsibilities and abilities of each organisation. This has facilitated open communication, and has allowed for gaps in communication to be quickly recognised and rectified.

The implementation of the fluoridation systems has been made in conjunction with upgrades to the chlorination systems and the delivery of significant water supply investment to maximise cost efficiencies. The upgrade to the chlorination systems was critical to the project as increasing the reliability and efficiency of disinfection, which protects public health by reducing exposure to disease causing micro-organisms.

Lessons, Challenges & Opportunities

This project is a successful and positive example of strategic partnerships at work. Both Power Water Corporation and the Department of Health do not have the capacity to carry out all components of this project alone, it necessitated working together; the successful completion of this project is testament to that.

The establishment of the partnership was assisted due to a number of key personnel in each agency already having purpose to liaise with each other. This facilitated conversations about the possibility of the project and enabled planning to go ahead.

This project was effective at working effectively with key government stakeholders involved in the project. At times the project was delayed because accurate contact information for community organisations was not immediately available. However, community information sessions were successful in all 5 sites. Community newspaper articles were available in 3 of the project sites.

The key barrier and challenge to completing a similar project in the future in other remote sites in the NT is funding for water fluoridation plants and recurrent funding for Essential Services Officers to monitor the effective functioning of the unit. PWC and DoH may need to work together to identify future strategies to access and utilise funding for further extension of water fluoridation.

Some key challenges in the implementation of this project included:

Remote locations in the NT have been the focus of the project - remoteness poses some logistical issues including; infrastructure, maintenance and cost.

Working in a cross-cultural environment - therefore health communication is also a challenge. However, innovative techniques were utilised throughout the project to minimise this.

Funding and recurrent funding to not only install the fluoridation plants but also maintain the plants is an ongoing challenge for future projects.

Some key opportunities in the implementation of this project included:

Spreading the message that drinking tap water is best also potentially will increase the population's consumption of tap water.

The planned installation of upgrading community disinfection systems to gas chlorination in growth towns can provide opportunities for installing fluoridation systems alongside these facilities.

Remote communities in the Top End of the NT have identified water fluoridation as a priority in their Local Implementation Plans (LIPS), a fantastic advancement as the importance for this public health initiative has been identified at the local community level. All larger remote communities have nominated Local Reference Groups that monitor the progress of the LIPS and are concerned with the wellbeing or needs of the community. The people who are selected to be a part of the Local Reference Groups (LRG) hold leadership positions in the community and are key conveyers of health information messages, this emphasises that these groups are influential within their community and crucial to the dissemination of positive information.

Health Promotion resources have been developed to communicate key health messages related to

both fluoridation and disinfection and disseminated through these meetings. These resources have been made specific to language(s) spoken at each site with content made culturally appropriate.

The National Health and Medical Research Council (NHMRC) is Australia's peak body for the achievement of the best possible standards for individual and public health. In 2007, the NHMRC commissioned a review to evaluate scientific data on fluoridation. The review affirms that water fluoridation remains the most effective and socially equitable means of achieving community wide exposure to the dental decay prevention effects of fluoride. It is recommended that further efforts be made to extend water fluoridation to other communities in the Northern Territory to ensure increased equity in access to fluoride.

Key Points of the Case Study

- The Strong Teeth, Healthy Bodies – A partnership between Industry, Community and the Department of Health is a successful example of cross Government and cross sector collaboration that directly impact on improved health outcomes for 5 remote Aboriginal communities in the Northern Territory, Australia.

- The project improved access to both disinfection and fluoridation of water supplies.

- The project used innovative approaches to health communication to ensure the community's health literacy in relation to water and in particular, water fluoridation was improved.

- There were other benefits to communities throughout this project such as improved awareness of the importance of good oral health, improved understanding of accessing healthy and safe drinking water and increased community action in the area of oral health.

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A Healthy Tasmania: Setting New Directions for Health and Wellbeing

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Project title: A Healthy Tasmania: Setting New Directions for Health and Wellbeing

Social determinants of health addressed: Inequity

Agencies involved: Whole-of-State-Government, Health Lead

Does case study describe a policy or a project or change to service delivery? Policy

Summary statement of case study.

A Healthy Tasmania is the Tasmanian Government's strategic policy direction to build good health and reduce avoidable inequities in collaboration with communities. Tasmania faces higher levels of poverty and locational disadvantage than other Australian jurisdictions, and strong community advocacy has driven the policy focus to what can be done to keep Tasmanians well and in control of what matters to them.

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To download the strategy visit:
www.dhhs.tas.gov.au/about_the_department/our_plans_and_strategies/a_healthy_tasmania

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Introduction

Tasmania is a small state of Australia with a dispersed population. Population growth over the next 20 years is expected to be modest, but the proportion of older people in Tasmania will increase more rapidly than elsewhere in Australia.

Tasmania also has higher levels of socioeconomic and locational disadvantage than other Australian jurisdictions. The Australian Bureau of Statistics' Socio-Economic Indexes for Areas ranks Tasmania as the second most disadvantaged jurisdiction in Australia. Thirty-eight per cent of the population live in local communities ranked amongst the most disadvantaged twenty per cent in Australia[7]. Tasmania had the highest rate of poverty (10.5%) of all jurisdictions reported in a NATSEM study in 2012[8].

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[7] ABS 2006 Census SEIFA data
[8] Catholic Health Australia -NATSEM 2012, Second Report on Health Inequalities

The ageing and socioeconomic status of the population have important implications for the health service system because older people and people who experience socioeconomic disadvantage have greater health needs.

The Tasmanian community has higher rates of preventable disease and their risk factors than other communities in almost all other Australian states and territories. These diseases are causing significant morbidity and mortality for individuals and are creating an unsustainable cost burden for the community.

While most Tasmanians are Australian born and speak English at home, a large number of overseas-born groups (including refugees) are represented by a small number of people. A further four per cent of the population identify as Indigenous[9]. It is challenging to provide necessary services in a culturally appropriate way to small numbers of people from broadly diverse backgrounds.

In 2008 when the World Health Organization (WHO) Commission on Social Determinants of Health released its seminal report *Closing the Gap within a Generation,* the Tasmania Health Plan was in its first year of implementation. Launched in May 2007 to meet the anxieties of the growing costs of healthcare and increasing community expectation, the plan drew on comprehensive stakeholder engagement and data analysis to build an integrated development of primary and acute care. There was a strong focus on improving pathways and linkages between services provided by the State, local or Australian Government, and services provided by the community or not for profit sectors.

The 2008 Tasmania State of Public Health report, which is published every five years and tabled in Parliament, identified that health inequities are a significant challenge facing Tasmania, and that this would need to inform service re-design and reform.

The community sector lobbied for action on the cost of living and the consequential costs of poverty under the TasCOSS campaign called "Our Island Voices". Interest in the social determinants of health and health inequity grew in Tasmania, both within and outside of government and was strengthened with the launch of the Health in All Policies approach of South Australia in early 2010.

The Tasmanian Government was identifying priorities beyond the active implementation of the Health Plan and responded in July 2010 with the *Fair and Healthy Tasmania Strategic Review*, led by Population Health Group in the Department of Health and Human Services. The Minister for Health, the Hon. Michelle O'Byrne MP, initiated the strategic review in order to find the best ways of improving health outcomes and reducing avoidable health inequities in Tasmania.

Concurrent to this the Chronic Disease Prevention Alliance who were active in the Health Plan implementation, brought together the Australian Public Health Association (Tas Branch), the Health Promotion Association (Tas Branch) and the Tasmanian Council of Social Service. They formed the Health in All Policies Collaboration that has consistently lobbied all Tasmanian Political parties for greater investment and action on the social determinants of health.

The Fair and Healthy Tasmania Strategic Review Final Report 2011 made two overarching recommendations to Government. It recommended the implementation of *leadership across sectors* and *place-based approaches* as the best ways of improving health and reducing health inequity in Tasmania. The purpose of these two actions being to drive intersectoral action at all levels (local, state, national) to shape the daily conditions that determine health and wellbeing in Tasmania (see Figure 1)

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[9] ABS Census 2011 data

Figure 1. Recommendations of the Fair and Healthy Tasmania Strategic Review

Towards the end of 2011 the Tasmanian Government responded to the findings of the *Fair and Healthy Tasmania Strategic Review* with the release of *A Healthy Tasmania: Setting New Directions for Health and Wellbeing.*

Policy Vision, and direction

A Healthy Tasmania is the Tasmanian Government's strategic policy direction for a fairer and healthier Tasmania. It is a long term approach for building good health and wellbeing in collaboration with communities. A Healthy Tasmania is about keeping Tasmanians healthy, well and in control of what matters to them.

A Healthy Tasmania also acknowledges that the daily conditions of living that determine a person's chances of achieving good health in the first place – education, employment, transport, poverty, early childhood and so on – lie outside of the control of the health sector.

As with all the biggest policy challenges facing Governments today, health inequity is a 'wicked issue' - complex and cross cutting. It cannot be addressed by one part of government acting alone. Through *A Healthy Tasmania*, the Department of Health and Human Services seeks to work in collaboration with all parts of government and the community.

A Healthy Tasmania identifies six streams of activity: leadership, health intelligence, supportive environments and policies, community-driven approaches, healthy messages and vulnerable Tasmanians. Potential actions are identified under each of these activity streams, to be implemented as support and resources allow (see Table 1).

Table 1. *A Healthy Tasmania* strategic directions and potential actions

Strategic Direction	Potential actions
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 Commissioning* – with the aim of funding services more effectively to meet the health and wellbeing needs of local populations.
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.
Build supportive environments and policies that will...	*Promote and Protect* – to make healthy lives and healthier choices easier through legislation, regulation and settings-based strategies (e.g. 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.
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 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 root causes of health are profoundly influenced by issues and actions across all sectors – like housing, education, agriculture and transport.
	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 we can address this.

Governance and Reporting Structures

Two governance mechanisms have been established to drive the *Healthy Tasmania* agenda forward across government and community.

A Health and Wellbeing Advisory Council has been established, made up of nine leaders of the Tasmanian community, dedicated to promoting and creating a fair and healthy Tasmania. Community members are voluntary positions, each is a leader in their own unique field. The Advisory Council draws representatives from the following sectors:

- the arts
- local government
- social services
- community and neighbourhood houses
- ageing
- private business
- health in all policies
- research.

The role of the Advisory Council is to inform and champion new solutions and approaches to improve wellbeing and reduce health inequity. It is supported by Population Health in the Department of Health and Human Services.

An Interagency Working Group focused on place-based approaches has also been established to help drive the necessary action across Tasmanian Government agencies. Each member of the Interagency Working Group is a senior leader in their own State Government agency with a strong understanding of the social determinants of health. The Interagency Working Group is also supported by Population Health in the Department of Health and Human Services.

Place-based approaches target specific neighbourhoods or communities. They can focus on the determinants of health in a location - like housing, employment or education - rather than a single risk factor or issue. Place-based approaches have been most simply described as stakeholders

engaging in a collaborative process to address issues as they are experienced within a particular place, be it a neighbourhood or a community.

Many of the place-based approaches that have been implemented do not focus specifically on health and wellbeing, but through their influence on the determinants of health, can have a substantial impact. For example, interventions that target housing, employment, early childhood, transport and social inclusion, are all likely to have flow on effects for health and wellbeing.

Policy implementation

Significant progress has been made following the release of *A Healthy Tasmania*.

In 2012 the Advisory Council established its foundations, endorsing a shared vision, terms of reference and communications strategy.

Quarterly meetings and workshops have been held, in which the members identified current issues in health and wellbeing in Tasmania, including the underlying conditions that determine a person's chances of achieving good health and wellbeing in Tasmania in the first place.

Council members have heard from public health experts on specific issues such as preventive health strategies, mental health, the early years, health inequity, the social determinants of health, place-based approaches and health in all policies approaches. There has been additional briefings, visits, advocacy and networking meetings.

A Health and Wellbeing Mapping Project identified the range of preventive health strategies currently underway in Tasmania, as well as some of the major activities of other sectors that have an influence on health and wellbeing. An analysis of the Mapping Project identified key factors that could be improved including that:

- there is a lot of work happening in Tasmania relating to health and wellbeing, but no clear coordination
- there are many health and wellbeing projects and activities aimed at individual behaviour change, but few that focus on the social determinants
- there is much talk of collaboration, but no formal mechanism between Government Agencies and between those Agencies and the wider community.

Issues Papers were also developed on key issues or strategies that were identified by the Advisory Council as priorities. The purpose of this was to raise awareness of the latest evidence and contemporary thinking in areas where opportunity exists to potentially enhance health and wellbeing. For example, through place-based approaches to health, arts and health initiatives, creative use of the opportunities in early childhood centres or the development of strategies to improve health literacy.

Members of the Health and Wellbeing Advisory Council carefully considered the advice, briefings, analysis and inquiry to date and called for a long term commitment to a thriving Tasmania. The Advisory Council's interim recommendations, presented in the next section, have been derived from this inquiry and will be developed more fully in 2013.

At the same time the Interagency Working Group focused on place-based approaches has also met quarterly, endorsed its terms of reference, identified shared goals across government and

considered the challenges and opportunities associated with the implementation of place-based approaches in Tasmania.

The community-driven campaign for action on the social determinants of health continued in Tasmania throughout 2012. The Health in All Policies Collaborative continued to lobby all political parties for action. A Social Determinants of Health Advocacy Network also formed and worked actively throughout 2012.

The purpose of the Social Determinants of Heath Advocacy Network is to "work together to leverage action on the social determinants of health so as to improve health and wellbeing outcomes for all Tasmanians." Membership of the Advocacy Network is open to all Tasmanians who share in this vision. The Network is facilitated by the Tasmanian Council of Social Service in partnership with the Tasmanian branch of the Australian Health Promotion Association.

There are now over 130 members of the Advocacy Network who regularly receive and share information relating to the social determinants of health. The Advocacy network has attracted media attention, published articles and presented to many groups and organisations, including the recent Senate Committee on the Australian Government's response to *Closing the gap within a generation.* The Advocacy Network also has produced a set of 'social determinants of health action sheets' for use by the Tasmanian government, business, community and individuals.

Case Study Outcomes

A major outcome of the *Healthy Tasmania* agenda to date has been the establishment of the leadership voice through the Health and Wellbeing Advisory Council and its analysis of health and wellbeing activities in Tasmania. This analysis has informed the Advisory Council's interim recommendations, included in an annual report for 2012 and submitted to the Minister for Health and Parliament of Tasmania. The Advisory Council has put forward four overarching recommendations to improve health outcomes and reduce health inequity in Tasmania (see Table 2) for their consideration. These are overarching recommendations that are supported by a further 30 potential actions recommended to drive change. These recommendations are interim and will be consolidated when the Advisory Council completes its sitting term at the end of 2013.

Table 2. The Health and Wellbeing Advisory Council's overarching recommendations (interim)

1. Communicate and empower
An effective health system is based on an understanding of the community context and underlying social determinants. Improving communication between government and communities will help empower Tasmanians to maintain and improve their own health and wellbeing.
2. Secure children's wellbeing for life
Assisting parents to give children the best start in life will increase their chances of achieving good health and wellbeing in the first place. A comprehensive approach must be taken that targets children and families and helps to build supportive environments.

3. Build connections across sectors
Addressing the underlying social determinants of health requires strong governance and intersectoral collaboration. Supportive infrastructure can help to build connections across sectors. Government must collaborate to identify and change policies and practices that influence health outcomes.
4. Invest in Systems
Creating the capacity within Tasmania to act effectively on health and wellbeing will require investment. Ensuring we have the right systems in place to monitor and evaluate the problem is one part of the solution. So is long-term commitment to public health approaches.

A Healthy Tasmania website has been developed to share information and resources on the social determinants of health with Tasmanians, including the work of the Health and Wellbeing Advisory Council.

In 2013 the Interagency Working Group will commence the development of a Place-Based Approaches Framework that will include the tools, resources, guidelines, governance and communications that will support Tasmanian Government agencies to implement place-based approaches. A series of case studies on collaboration will also be developed by the group to illustrate and share best practice across agencies.

The Department of Health and Human Services has also commenced the development of a *Health Equity Framework* for Tasmania that will see the implementation of health equity impact assessment, health equity population profiling and health equity indicators beginning in Tasmania from 2013 onwards.

A major achievement of the community-driven campaign for action on social determinants of health in Tasmania has been the establishment of a Joint Select Committee that will form in 2013 to consider the Tasmanian Government's response to the social determinants of health. The Select Committee has formed in response to calls from the Tasmanian community for further action on the social determinants of health, particularly from the Health in All Policies Collaborative. The Select Committee will take written and personal submissions during the early part of the year and is scheduled to draw its conclusions by the end of September 2013.

Policy Monitoring

Policy progress will be monitored through the release of regular *State of Public Health Reports*, required every five years by legislation in Tasmania under the *Public Health Act 1998.*

Challenges and Opportunities

The major challenges and opportunities associated with the *A healthy Tasmania* agenda are identified as follows;

Challenges:

Taking a health in all policies approach to addressing the social determinants of health requires the strategic commitment of multiple stakeholders in the State Government, as well as the involvement of Local Government, private and community sectors. This extensive collaboration creates a significant challenge in reconciling divergent perspectives and agendas. Governance approaches for partnership and collaboration are poorly defined and developed and many stakeholders are unlikely to realise the benefits which are hard to attribute, and will only be evident over the long term.

It is difficult to establish and sustain effort and investment in preventive health when organisations are affected by increasing demand for services and public opinion influences political agendas according to election cycles. The rising burden of chronic conditions across middle income countries plays a critical role in increasing the demand for services and often draws the focus away from the more complex policy area of primary prevention and the determinants of health. Whilst the need for a focus on the social determinants of health is broadly acknowledged it is challenging to secure a strategic and long-term government policy agenda.

Like many Australian jurisdictions, Tasmania has experienced considerable budget restrictions following the global financial crisis and loss in tax revenue. This environment has caused greater demands on the economy and Tasmania faces the highest levels of unemployment and under employment in the country. Within the State Government, this has impacted on limiting the human and financial resourcing available for central policy coordination and implementation. As a result stakeholders across sectors are also time poor for maintaining commitment and integrating collaborative effort. In addition to the governance challenges in Tasmania, the social determinants span national policy and international systems such as welfare policy and the food industry, and these operate outside the control of State Governments.

Opportunities:

Despite the complex challenges in working across sectors to address the social determinants of health, Tasmania is well positioned to take advantage of a number of opportunities to progress this work. Tasmania is a relatively small State and relationships of trust and collaboration can be made and maintained. The advocacy and lobbying by community sector organisations and more recently the individual members of the Social Determinants Advocacy Network, have provided leverage for the small, but sustained investment to date in the leadership by the Population Health Group within the State Government Health Department.

There is substantive opportunity for further development of policy and practice across and between Government agencies, especially if a strategic commitment can be more firmly established in the next year. The Minister's Health and Wellbeing Advisory Council will provide its formal recommendations for consideration by parliament in 2013. The recommendations will be developed consultatively with key stakeholders to include a structured requirement for interagency collaboration, as well as the models and principles for community driven action.

The State Government's central agency, Premier and Cabinet, released a collaboration strategy in 2011 which provides a leadership directive to work across government on complex policy issues. There is a budget strategy for the whole of Government released by the Premier in December 2012

that includes a commitment to prevention and tackling inequities. There is a commitment by all agencies to share data, use a spatial data platform, and establish a shared information strategy to improve economic and social outcomes for Tasmanians. The State's Economic Development Plan released in 2011 includes a commitment to sustainable economic and social development in the regions, and an investment in social enterprise and micro business support and development. Population Health works with the Premier on Physical Activity, Health and Wellbeing at Work, and Food Security. *A Healthy Tasmania* provides a coherent overarching strategic direction for health and wellbeing in Tasmania that can further integrate these programs and strategies and formalise the shared responsibility and commitment to reducing avoidable inequities.

The Joint Select Committee inquiry into the social determinants, integrated service delivery and funding models for preventive health embodies a valuable opportunity to develop preventive health policy that transcends individual political agendas and lays down a solid foundation for a long term commitment to health equity.

At the national level, in the current financial year of 2012-13 the Australian Government has committed a healthcare funding package over four years to assist the Tasmanian Government to continue providing quality health services amidst the budget crisis. A significant portion of this funding has been allocated to the Tasmanian Medicare Local to provide clinical pathways, coordinated care and to reduce the impact of risk factors and support ways to address social determinants for health and wellbeing. Medicare Locals were established in each state by the Australian Government during the National Health Reform as the organisations responsible for coordinating primary health. This national funding will substantially augment the local capacity to develop action on the social determinants.

Key messages and learning

Tasmanian experience gained so far indicates that intersectoral collaboration is an important mechanism for tackling the social determinants of health and health equity, and that it takes time, effort and commitment to secure the interest. It is evident that structured, high level leadership is required to drive intersectoral collaboration across government, community and private sectors for the benefit of all. The substantive economic and rational arguments for benefit are emerging and not yet clearly articulated, but there is a clear realisation that the cost of doing nothing is significant. It is also apparent that lead agency responsibility and resourcing is essential for establishing intersectoral relationships. If limited resources exist, there is a need to tap into existing resources elsewhere and draw on the in-kind support from partners. High level leadership has to be directly connected with local action and activity that is owned and driven by the community to ensure results are responsive to local needs.

It is important to explain the social determinants of health in plain language to ensure that diverse stakeholders recognise the importance and relevance to their role. Identifying areas of shared interest can also help to gain intersectoral buy-in. For example, transport is a shared interest for many sectors including business, environment and health.

Once key stakeholders are engaged, it is important to look for practical actions that can be implemented and start with small steps. In this context timing is everything. Seize opportunities when they present themselves and share the responsibility and accountability. As the momentum

starts to build remember to celebrate wins and keep on going. Continuity of effort and prioritisation are essential to maintain ongoing momentum for intersectoral action.

Housing for Health in NSW – a healthy housing intervention

> **EXECUTIVE SUMMARY**
>
> **Project title:** *Housing for Health* in NSW – a healthy housing intervention
>
> **Social determinants of health addressed:** Housing
>
> **Agencies involved:** New South Wales (NSW) Health and NSW Aboriginal community housing providers.
>
> **Does case study describe a policy or a project or change to service delivery?** Project
>
> **Summary statement of one or two sentences describing key strategy and target audience of case study.**
>
> New South Wales Health's ('NSW Health') *Housing for Health* uses a survey and fix methodology to improve living conditions in Aboriginal community housing. The process aims to assess and repair or replace health hardware so that houses are safe and support health. First trialled in 1997, clearly measurable and demonstrable improvements have been made to both the condition of houses in communities where *Housing for Health* interventions were implemented and to the rates of infectious disease hospitalisation for residents of those houses.
>
> **Key contact and/or website:**
>
> Aboriginal Environmental Health Unit
>
> Health Protection NSW
>
> enhwu@doh.health.nsw.gov.au
>
> Copies of the original case study can be downloaded from the NSW Health website:
>
> http://www0.health.nsw.gov.au/pubs/2010/pdf/housing_health_010210.pdf

Introduction

The World Health Organization's *Commission on the Social Determinants of Health* recognises poor housing as one of the main social causes of ill health[10]. Housing can impact on health in many ways – is there enough space for all family members to live comfortably? Do children live in neighbourhoods where it is safe to play outside? How is the house built, and does it have the necessary construction and physical conditions to ensure a healthy environment[11]?

In 2008, an estimated 156,554 Aboriginal people lived in New South Wales (NSW), the largest Aboriginal population of any Australian state or territory, comprising 2.3% of the total State population. Larger proportions of Aboriginal people than non-Aboriginal people are unemployed, have no post-school qualifications, no household internet connection, a weekly household income less than $500, rent, live in multi-family households, and reside in dwellings containing seven or more people[12].

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[10] World Health Organization (2006). *Social Determinants of Health Fact File*, World Health Organization, Geneva. Viewed 6th February 2013. http://www.who.int/features/factfiles/sdh/01_en.html

[11] Maier N (2006). *Housing as a Social Determinant of Health: Policy Brief prepared for the Middle Childhood Initiative of the National Children's Alliance*, National Children's Alliance, Ottawa. Viewed 6th February 2013, http://www.nationalchildrensalliance.com

[12] Centre for Epidemiology and Evidence (2013). *Health Statistics New South Wales*. NSW Ministry of Health, Sydney. Viewed 22nd January 2013, http://www.healthstats.nsw.gov.au

This relative socioeconomic disadvantage experienced by Aboriginal people in NSW places them at greater risk to behavioural and environmental factors that negatively affect health than the general population, including poor living environments, substandard and overcrowded housing and poor sewerage and water quality[13].

In 2008, the Council of Australian Governments (COAG) agreed to an historic National Partnership Agreement (NPA) to close the gap between Indigenous and non-Indigenous health outcomes. This agreement commits Australian governments to closing the gap in life expectancy within a generation and to halving the gap in mortality rates for Indigenous children within a decade. One of the Aboriginal health initiatives helping to achieve these goals is the *Housing for Health* program.

Housing for Health uses a 'survey and fix' methodology for improving living conditions in community housing. The *Housing for Health* process aims to assess, repair or replace hardware so that houses are safe and support health. Research has shown that improving essential hardware (such as fixing a leaking toilet, electrical repairs, ensuring sufficient hot water for the number of tenants, having somewhere to wash a baby or child, etc.) can lead to improvements in health status and reduce the risk of disease and injury[14].

By focusing on repairs and maintenance of Aboriginal community housing, with a specific focus on improving safety and health for residents in those homes, *Housing for Health* directly addresses housing as a social determinant of health.

Vision, Aims, Objectives

Underpinning principles
The *Housing for Health* survey process is a key measure to improve the environmental health conditions in Aboriginal communities and ensure Aboriginal people have improved health and longer lives. Progress is measured through the nine evidence based Healthy Living Practices listed below. Budgets for projects are comparatively small, so all works carried out in the *Housing for Health* program are prioritised in terms of health benefit. The priorities are:
a) Safety – immediate life threatening dangers, particularly electrical, gas, fire, sewage and structural safety issues are addressed as the highest priority.

b) Healthy Living Practices – after safety issues have been addressed, the prioritised list below from 1 (most important) to 9 (least important) provides a focus for prioritising repair and maintenance:

1) Washing people - ensuring there is adequate hot and cold water and that the shower and bath work.
2) Washing clothes and bedding - ensuring the laundry is functional with separate taps and drainage for the washing machine and tub.

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[13] Australian Indigenous Health*InfoNet* (2008). *Review of the impact of housing and health-related infrastructure on Indigenous health.* Australian Indigenous Health*InfoNet,* Mt Lawley. Viewed 21st January 2013. http://www.healthinfonet.ecu.edu.au/determinants/physical-environment/reviews/our-review
[14] Pholeros P, Rainow S, Torzillo P (1993). *Housing for Health*: Towards a Healthy Living Environment for Aboriginal Australia. Healthabitat, Newport Beach.

3) Removing waste safely - ensuring drains aren't blocked and that toilets and sewerage are working properly.
4) Improving nutrition - assessing the ability to prepare and store food, making sure the stove works and improving the functionality of the kitchen.
5) Reducing overcrowding - ensuring hardware (particularly hot water systems and septic systems) can cope with the actual number of people living in a house at any time.
6) Reducing the impact of animals, vermin or insects – for example, ensuring adequate insect screening.
7) Reducing dust – to reduce the risk of respiratory illness.
8) Controlling temperature – looking at the use of insulation and passive design to reduce the health risks, particularly to small children, the sick and the elderly.
9) Reducing trauma – reducing other non-life threatening hazards that may injure or cause trauma to residents.

While all of the healthy living practices are important, the first four points are considered critical, as they are essential for people to be able to live healthy lives.

In addition to clearly prioritising works to address evidence based safety and health function in homes, there are a number of other key principles of the *Housing for Health* methodology that contribute to its success. These are described in the case study description and include:

- Community engagement in the project.
- A principle of "No survey without service". Faults identified during survey are addressed immediately.
- Building local capacity by using local tradespeople to work with the community.
- Maximising training and work opportunities for local community members.
- Accountability through the systematic collection of before and after data on house function to record each item repaired; demonstrate change, and identify a prioritised list of future works (beyond the scope of the limited budgets).
- Financial accountability that can demonstrate expenditure on each item by trade and by house.
- The collection of data by tradespeople on the cause of failure of all items repaired to drive better housing policy.
- Confidentiality. All data are de-identified to ensure confidentiality.
- Quality assurance of specified materials and workmanship.

National and international context
The health disadvantages suffered by Indigenous people are a major focus of policy at national and state and territory levels in Australia. The link between housing and health is reflected in national policy, which has recognised the need to integrate health and housing outcomes. The *First Steps in Closing the Gap – Australian Government Budget 2008-09* states: "A healthy home is a fundamental precondition of a healthy population. Children need to live in accommodation with adequate infrastructure conducive to good hygiene and study and free of overcrowding."[15]

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[15] Commonwealth of Australia (2008) Closing the gap between indigenous and non-indigenous Australians. Available at http://www.budget.gov.au/2008-09/content/ministerial_statements/html/indigenous.htm

Concerns about balancing housing and health outcomes are not unique to NSW or Australia, but have also been identified by the World Health Organisation as a key social determinant of health.

A different methodology

Repair and maintenance programs for community owned housing may include some safety and health priorities, however they are primarily focussed on ensuring successful tenancies and maintaining the assets. Funding is usually delivered on a financial year basis.

NSW Health's *Housing for Health* program differs in that it focuses primarily on improving the health of tenants (in particular, children aged 0-5 years) by improving the health hardware within the homes, ensuring a minimum basic level of safety and health across all houses. The community is actively engaged in the process of assessing and auditing the works at the start and finish of the projects. Funding is delivered on a project basis and may cross financial years.

Governance and Reporting Structures

Housing for Health projects have been delivered by NSW Health, in partnership with Aboriginal communities. Projects are funded by NSW Health, and where possible, NSW Health has also worked with state and federal housing agencies to extend this work and integrate it into larger housing programs.

Progress made through the *Housing for Health* program is measured through improvements in the nine critical Healthy Living Practices mentioned earlier. Progress in *the program* plays a key part in fulfilling the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: Implementation Plan (NSW)*.

Case Study Outline and Description

The *Housing for Health* program encompasses 5 main stages:
1. Community consultation and feasibility
2. Survey Fix 1
3. Capital Upgrade
4. Survey Fix 2
5. Reporting and closure

When Aboriginal communities agree to participate, a survey-fix week is set aside and a number of community workers are trained to work alongside technical staff to inspect, test, and record around 250 items in the houses, and where possible, undertake fix work. *Housing for Health* has an underlying principle of 'no survey without service' so survey teams carry a small tool box to undertake basic repairs to houses (unblocking drains, replace light globes etc).

Work lists are given to qualified tradespeople who follow about a ½ day behind the survey teams repairing urgent items that require specific trade skills (mostly plumbing and electrical work). Larger non-urgent works (new hot water systems, waterproofing showers etc) are undertaken over the following months. A second survey-fix is then scheduled to ensure all priority works are complete, to evaluate the capacity of the house function, and to allow the community an opportunity to audit the work of the project.

All works carried out in the program are prioritised in terms of evidence-based health benefit. Projects have a comparatively small budget, so all works are tightly prioritised to maximise health gain and ensure houses are safe and occupants have the ability to carry out healthy living practices.

Disempowered populations are associated with poorer health outcomes, so this program engages the community throughout the projects. *Housing for Health* recognises the importance of local community knowledge and involvement in improving the housing hardware. Community members form around 80% of the 'survey and fix' teams that identify where the hardware is failing, and direct the work of tradespeople. The survey and fix teams return after the capital upgrade process to survey again and ensure works have been carried out. This also provides an opportunity for the community to audit the works carried out under the program.

Wherever possible, the program encourages the use of local tradespeople to carry out the works, and is committed to utilising Aboriginal building companies or local tradespeople. This approach provides an opportunity for the community to build a relationship with suitable local tradespeople that will last beyond the life of the *Housing for Health* project. Local tradespeople are encouraged to employ an assistant from the community and in a number of cases this has led to full time employment, including apprenticeships with those tradespeople beyond the completion of the project.

Quality assurance is a strong component of the project. Robust materials are specified to cope with often crowded conditions. The use of cheaper alternatives creates a false economy as they require replacement more regularly. Inspections of work throughout each project ensure high standards of workmanship and any tradespeople that cannot deliver the service on time and to standard, are removed.

Case Study Outcomes
Since 1997, *Housing for Health* projects have been run in 2826 houses across 86 communities around NSW. The program has benefited around 12,100 people and well over 81,000 items that relate to improved safety and health have been fixed in those houses. This has led to measurable and demonstrable changes in the condition of those houses to support healthy living.

An evaluation of the *Housing for Health* methodology also found that the process augmented the capacity of communities to undertake basic asset management functions. In NSW, the lack of routine maintenance in homes accounts for 67% of all items fixed under the program; 28% are due to faulty workmanship or poor specification of materials, and only 5% of items are damaged by tenants.
 Program outputs for *Housing for Health* included:
- Nine-fold improvements in electrical safety
- Four-fold improvement in fire safety
- Over two-fold improvement in structural safety and access in houses
- Over two-fold improvement in the ability to wash people and to wash clothes and bedding in homes
- Two-fold improvement in removing waste safely from homes
- Over three and a half-fold improvement in the ability to prepare, store and cook food at home.

By delivering immediate and tangible improvements to housing, the program has built a bridge of goodwill between communities and public health units which has enabled them to run various other public health programs. These other projects have included injury prevention, fire education,

electrical safety education, health screening, community clean-ups, vermin reduction, water monitoring and service improvement.

Finally, an evaluation of the program undertaken by NSW Health has shown positive health outcomes. Residents of houses where the *Housing for Health* intervention was implemented had a significantly reduced rate of hospital separation for infectious diseases – 40% lower than for the rest of the rural NSW Aboriginal population where *Housing for Health* interventions were not implemented[16].

Monitoring and Evaluation

The *Housing for Health* program aims to provide an equitable level of basic safety and health in housing. *Housing for Health* projects are not ongoing in each community. Each project has a defined start and finish. However, many of the gains from the program are sustained.

An assessment of the sustainability of the program's impact was undertaken in a community in Western NSW. This community was chosen as its initial program was completed 2 ½ years prior, and the community had not had a maintenance program since that time. A third Survey-Fix was undertaken to evaluate the durability of program effects.

The survey results demonstrated that, while a few minor items required repair, most of the gains in house function from the original project were sustained and little effort (and funding) was required to return the houses to a similar standard of function. The specification of materials of a suitable quality (such as good quality taps rather than the cheapest options) was a major contributor in sustaining these achievements.

Reflections on NSW Health's *Housing for Health* initiative

Challenges

Delivering a community based program like *Housing for Health* as a statewide initiative has led to some challenges. Working with Aboriginal communities may at times require flexibility around timeframes to accommodate community priorities. However, provided the community are given due respect, are involved in the process and that the limitations (as well as the benefits) of the projects are clearly communicated to the community up front, there are few challenges encountered in the implementation of this project.

The greatest challenges come from implementing a community based program within a government framework. Government procurement processes and accounting systems often favour larger businesses based in cities and regional centres over small local businesses that are not resourced to submit detailed tenders, carry high levels of insurances required by government contracts, or cope with often long delays in payment of invoices. Addressing these issues and establishing clear systems is critical to ensure the program can operate within the principles of the methodology.

Collaboration across government agencies also has its challenges. There is a need for staff from all partnering agencies to consider the larger picture and possibly change the way they have always

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[16] NSW Ministry of Health (2012) Closing the gap: 10 Years of *Housing for Health* in NSW. An evaluation of a healthy housing intervention. Available at
http://www0.health.nsw.gov.au/pubs/2010/pdf/housing_health_010210.pdf

done business. For interagency collaboration to be successful there is a need for support from all levels of all organisations, and key to its success is to have at least one influential champion in each agency to drive the collaboration and necessary changes within their organisation.

Opportunities
As this evaluation of the *Housing for Health* program has demonstrated significant health gains it is important to explore if and how the methodology can be adopted more broadly for social housing, in particular Aboriginal housing.

NSW Health has been seeking ongoing opportunities to collaborate with Housing NSW and the Aboriginal Housing Office on a partnership approach to exploring new models that ensure optimal health outcomes from housing interventions. This will require skills transfer and development across agencies and the collection of appropriate data, analysis and interpretations to facilitate future funding.

Conclusions
Housing for Health has had a significant impact on improving the health of Aboriginal people in NSW who took part in the program. The significant gains experienced by Aboriginal populations exposed to *Housing for Health* will have direct and indirect cost benefits to the health system and more broadly to society. Direct benefits include the cost of care for people admitted to hospital, in the present and in the future through the reduction of chronic disease. Indirect benefits include the cost to employees or employers in productivity and associated leave entitlements for those affected and their carers.

The results of this study are significant, and have implications for the delivery of Aboriginal community housing and, potentially, for the whole social housing sector.

Key Points
- By focusing on undertaking specific repairs and maintenance of Aboriginal community housing that focus on improving safety and health for residents in those homes, *Housing for Health* directly addresses housing as a social determinant of health.

- Outcomes of the *Housing for Health* Program can be measured in terms of health and house function. Measurable and demonstrable improvements have been made to the condition of houses and the rate of hospital separations for residents in communities where *Housing for Health* projects were implemented.

- The nature of this study and the magnitude of improvement demonstrated warrants consideration for the future delivery of repair and maintenance in social housing.

Victorian Public Health and Wellbeing Act 2008

Introduction:

The Victorian Public Health and Wellbeing Act 2008 (the Act) is arguably one of the most progressive pieces of Public Health legislation in Australia, and innovative in introducing a principle approach that includes prevention at its core. This makes it an interesting case study internationally as it successfully brings together a range of health promotion and health protection areas in a single piece of legislation by applying the same tests to them.   Thus, in addition to its role in strengthening and modernising core public health responsibilities, the Act through its legislated powers and requirements, provides an important authorising environment and context for partnerships, engagement and action beyond the health care portfolio in the promotion and protection of population health and wellbeing.

In particular, the Act states among its principles, the "primacy of prevention" stating that the prevention of disease, illness, injury, disability or premature death is preferable to remedial measures. The principles also recognise that public health and wellbeing can be enhanced through collaboration between all levels of Government and industry, business, communities and individuals, resulting in a Health in All Policies (HiAP) flavour in the legislation by giving a legislative basis to existing Victorian practice of collaboration that had been part of the local environment since earlier amendments to the Health Act that had mandated municipal public health planning (MPHP).

In this vein, the Act includes requirements for a State Public Health and Wellbeing Plan, which takes account of the determinants of health, to be prepared every four years; and for public health and wellbeing plans to be prepared by local government. Under certain circumstances, the Act allows for these health and wellbeing plans to be incorporated in a strategic plan at the local government level. Promoting conditions in which persons can be healthy and reducing inequalities in the state of public health and wellbeing are included in the Act's objectives. This formalised existing practice in Victoria which had extended the WHO Healthy Cities concept through a policy platform *Environments for Health*[17]*,* which had given policy authorisation to regular municipal public health plans and given local government authorities an impetus to adopt a public health approach in their planning and operational frameworks.

Reviewing the development of legislation in Victoria provides an example of how public health evolved in the modern state where there had evolved a recognition that the social determinants of health required a much broader focus than a single department could bring to bear on a range of

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[17] On Environments for Health http://www.health.vic.gov.au/localgov/

population health matters and on health outcomes as a whole across the community. This case study examines how this Act came about, the debates and issues that surrounded its development, and the implications that the Act has had, directly and indirectly, for multi-sectoral action for health improvement in the state of Victoria.

Vision, aims, objectives

The genesis of the Victorian Public Health and Wellbeing Act 2008 lies in two seemingly very different strands: first the economic reforms of the 1980s which opened the Australian economy, and second, the gradual development of the so-called new new Public Health. They shared an essential reform component. Both were aimed at modernisation.

The Act is a successor to a number of earlier pieces of legislation that governed the Public Health in Victoria, mainly in terms of sanitation and safety. In 1988 earlier legislation was consolidated and amended mainly with the advent of the HIV/AIDS epidemic, that introduced a number of innovative responses and brought together for the first time concepts from health protection and social approaches to health which were beginning to inform new thinking in public health.

At about the same time there was a widespread debate in the public health community about the breadth of the field and reflected a growing concern that health inequalities and the failure of primary health care to adequately provide solutions in community health, the prevention of disease and health promotion that had been enunciated in the Alma Ata Declaration and expanded in Ottawa Charter for Health Promotion .

History and Background

The first serious discussion of recent reform occurred in 1999 with the release of a discussion paper that came from the need to address a Council Of Australian Governments (COAG) agreement on national competition policy. The States were compelled by the COAG Agreement to review legislation that included regulatory frameworks, and the then State health legislation fell into that ambit, as it was highly regulatory in flavour.

The Health Act 1958 was the result of a patchwork of amendments to Public Health legislation in Victoria. The first public health act in Australia followed the first English Public Health Act of 1848. Victoria enacted an Environmental Health Act in 1854 and gradually built a comprehensive legislative framework to protect the public health. The most recent amendments in 1988 had been in response to the emergence of the HIV/AIDS epidemic[18], recognised the social determinants of health that had been enunciated in the various WHO statements, and strengthened health protection as a key and central focus of legislation to protect the health of the public .

The November 1988 discussion paper noted a comment by Reynolds that

> "*public health laws are by their very structure controversial and will never be free of criticism they engage and often challenge a range of other social values particularly those that support the right to be left alone or call for this regulation.*"[19]

In fact that statement included one of the key drivers for reform in the longer process of development of the final 2008 act of Parliament - the economic modernisation reforms that encompassed deregulation and increased competition. Even as the discussion was beginning the tensions in the discussion paper were emerging with strong statements that to purport that interfering by regulation

> "*with people's rights have often been counter-productive to good public health outcomes*"[20]

in fact there were objects inserted in the Health Act in 1988 that were never proclaimed, in particular objects that stated

(a) *to ensure equity and health; and*
(b) *to help people live as full a life as possible no matter what their health; and*
(c) *to reduce the incidence of disease disability distress symptoms of health; and*
(d) *to reduce the untimely death*

These objects reflected the growing consensus among the health practitioners that was adopted by the World Health Organization in the 1978 Alma Ata Declaration, and expanded in the 1986 Ottawa Charter for Health Promotion and succeeding documents.

The fact that they were not proclaimed suggests that there was both a bureaucratic and political struggle that mirrored the tensions between the two strands of thought that were driving reform - economic modernisation deregulation, and growing support for equity and tackling health inequalities, thus tackling the social determinants of health

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[18] Review Of The Health Act, 1958, Discussion Paper, p 5
[19] Reynolds C "*Ideas and arguments that public health law,*" a paper commissioned by the legislation reform working group of the National Public Health Partnership (NPHP), March 1999 cited in the discussion paper, p 6
[20] Ibid, p 6

Competing ideas

The two strands of thought that drove the redevelopment of public health legislation in Victoria were quite well enunciated in the 1998 discussion paper. In this section of this case study we will look at the arguments that were advanced for each of the ideas and discuss how they may have been relevant in the formation of the final legislation.

The social determinants of health (the new new public health)

At the time of its drafting in 1998 there was significant discussion both in Victoria and nationally to the ideas of intersectoral collaboration joined up government and/or whole of government collaborations[21]. The Victorian discussion paper noted the importance of many players involved in the delivery of health outcomes and in particular concentrated on the role of local government which in Victoria played a "crucial" role in the delivery of public health services. At the time Victoria was engaged in the development of major policy initiative which became known as *Environments for Health*, which was updated in 2008 and which became the basis for significant new policy developments in prevention of chronic disease. *Environments for health* was also influential across government with many of its ideas being picked up in the establishment of the Department Victorian Communities and a strong focus in Victoria that emerged on community strengthening and community development.

There was an explicit proposal in the discussion paper[22] to provide the secretary with the types of powers that had been included in the 1988 consolidations to the health act but had not been proclaimed. These included inter alia to:

- *promote independent research*
- *analyse impact broad range of current and proposed public policies*
- *plan for changing social conditions*
- *equip individuals and local communities to take responsibility for their own health*
- *develop and enforce up-to-date public health standards*
- *monitor the activities and to assist other agencies which had an impact on public health*

This proposal reflected the recognition that the determinants of health may well lie outside the control of health departments, health systems or health practitioners and were consistent with calls

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[21] a number of the other case studies this volume illustrate the focus of governments in Australia different jurisdictions on intersectoral collaboration joined up government. See also Hyde "*making the rhetoric of joined up government really work,*" (2008), http://www.anzhealthpolicy.com/content/pdf/1743-8462-5-22.pdf , and Baum F The New Public Health, (OUP 1998)

[22] Review of The Health Act, 1958, Discussion Paper, p 9

in modern public health discourse to encourage collaboration and coordination across government and communities to promote and protect the public health

The consolidated Health Act 1958 which had been amended in 1988 had provided Victorian local governments with a number of front-line operational activities in traditional public health matters with the Health Department having a policy oversight regulatory role. This model differed from other Australian jurisdictions by taking public health closer to communities and in part reflected the strong traditions in Victoria of community engagement and a vigorous not-for-profit community-based sector.

The existing legislation already included provisions for councils to prepare municipal public health plans every three years that were subject to the agreement of the secretary. This history of local government engagement was to become a crucial factor in the development of later public health and prevention efforts (ie with the development of the Victorian Community Prevention Model *Healthy Victoria Together* that was established in response to the National Partnership Agreement on Preventive Health in 2010).

National competition policy (economic rationalism)

National competition policy was agreed to at the 1995 COAG meeting. It committed all Australian governments to review all legislation and regulation that were considered to restrict competition and implemented a reform timetable for reforms.

- There were some exemptions that were allowable, so where possible public health practitioners sought to define regulations that lead to health protection and reduction in health inequalities within the context of these exceptions *the benefits of the restriction to the community as a whole outweigh the cost and* where
- *the objectives of the proposed policy and legislation can only be achieved by restricting competition*[23]

Indeed, the Victorian government's guidelines review of legislative restrictions on competition stated

> "the guiding legislative principle established under the competition principles agreement does not imply competition objectives should take precedence over these important policy objectives. However, the form which regulation takes often creates unwarranted barriers to entry to relevant markets, limiting choice, stifling innovation and generating monopoly rents for existing producers which result in higher prices for consumers higher prices to consumers.[24]

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[23] Review of The Health Act, 1958, Discussion Paper, p 13
[24] Victorian Government's *Guidelines for the Review of Legislative Restrictions on Competition, 1996, p 29* cited in Ibid, p14

This allowed public health officials to find innovative ways to justify maintaining (and in some cases extending) regulation under the proposed new act. Some of the regulations that were to be reconsidered were quite new, in particular, those relating to infectious diseases which had been developed in response to the emergence of the HIV/AIDS epidemic and which covered not only social health responses but also infection-control in hairdressers, tattooists and piercing businesses. Many of the other regulatory approaches were aimed at ensuring local health protections through licensing schemes for radiation and pest control. While these regulations did have some effect on small local businesses they had developed because of local demands for health protection.

Interestingly the management of public health risk differed between jurisdictions and in the public's perception there was more concern about inconsistent application of regulation, for example, in infection-control for blood-borne diseases such as HIV or hepatitis then there was for reduction in competitiveness in the hairdressing, tattooing and piercing businesses or in the medical profession than there was for public safety. Similarly there was no discernible public demand for limiting regulation in the areas of food safety or in control of local nuisances by local government. In most of these areas regulation survived the review with relatively minor changes and over the following years a number of areas were brought under regulation.

What did happen was increased pressure for a review and modernisation of public health legislation to take into account those new directions that have emerged with the new public health and in particular to codify the lessons and advances of public health approaches that recognised explicitly the social determinants of health, health inequalities and the inter-sectoral nature of health determinants. Within public health community, there was a move to give a more explicit legislative base to public health. While work on such reforms continued within the Health Departments it was in many ways focused and lead through the academic work of Reynolds under the auspices of the National Public Health Partnership (NPHP) which enabled the Australian jurisdictions to take a more consistent and compatible approach to public health modernisation and to resist some of the more strident demands for more comprehensive deregulation area.

In Victoria it also enabled further discussion around those areas of social health and the social determinants that had been included in the 1988 amendments to the health act which had not been proclaimed.

Policy Development Process

The review of legislation process occurred over a decade. In the immediate aftermath of the 1998 discussion paper, draft legislation take into account recommendations arose from the competition

policy review process. The Health Amendment Act 2001 gave effect to the government's response to review of Health Act 1958 and a number of associated regulations. The amendments were not extensive and were mostly limited to removing duplication where it existed in other state legislation or in Commonwealth legislation. Finally it clarified a number of those areas to do with the management of HIV that had been introduced in the previous amendments to the Act.[25]

Following a hiatus in the Department, the review recommenced in 2002. Further consultations with academics and public health practitioners led to another discussion paper that was released in August 2004. This discussion was much more rooted the human rights strand of public health and the focus that population health is bringing to the debate not only concentrated on broad range of accepted risk factors that had informed recent health promotion practice but brought to the discussion the idea of principles-based legislation. This idea was to survive throughout the rest of you processes which last 2007 the purpose of the paper was to take into account "*significant developments in scientific social and policy areas of public regulation*."[26]

By this stage review of the act and turned more fully to the principles of the charter and the debate around human rights and public health. In doing so it aimed to bring together all strands of public health to be dealt with in a modern legislative framework that encompassed clear public health objectives, transparent and accountable public health strategies, take account of public health risk and the social determinants of health, make impact and effectiveness targeted and finally attempted to bring together risk management provisions for both health promotion and protection.[27]

The adoption of a principle's approach for inclusion in the legislation reflected contemporary international discussion especially in integrating advances in science and recognising emerging global risks. The discussion paper proposed the adoption of the following principles[28]:

- evidence-based decision-making
- the precautionary principle
- accountability
- community interest in public health
- preventing unnecessary encroachment on individual rights
- polluter pays principle
- collaboration and inter-sectoral effort

A power to undertake health impact assessments had been included in the 1988 amendments to the Health Act, and was one of the provisions not proclaimed. The adoption of these principles

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[25] Victorian government response to the national competition policy review of the health act 1958, February 2001, http://health.vic.gov.au/phwa/downloads/ncpr_govtresp.pdf

[26] review of the Health Act 1958: a new legislative framework for public health in Victoria, a discussion paper, August 2004,p 4
[27] Ibid, p 8
[28] Ibid, pp12-15

strengthened proposals to retain such a power in the new Act, even though there was little appetite at senior levels of the Department of Health or central agencies to engage such a power. It was to remain an important power as it became influential in later developments including the establishment of a whole of government Prevention and Population Health Board that brought into practice a Health in all policies focus and became a whole of government driver for the development of the State Health and Wellbeing Plan.

Following further public consultation which included the release of another discussion paper[29] that responded to the number of the matters that had been raised in 2004, the stage was set for the draft of a new piece of public health legislation that adopted quite far reaching ideas that were aimed to provide a framework for managing public health in Victoria. The new discussion paper noted and addressed significant matters that had arisen during the consultation process, including a proposal for a broad power to enable public health officials to conduct public of enquiries (HIA) and to strengthen the important role that have emerged for local government public health policy and planning through municipal public health. The discussion paper also affirmed Victoria's strong attachment to a creditable risk management approach through statutory power and regulation in the area of health protection.

History would show that these new directions and reaffirmation were prescient, as within a decade Victoria was faced with some significant challenges that included a major climate event in widespread wildfires, an avian flu outbreak, significant salmonella outbreak and cases of imported polio and tuberculosis it was also a use the roadmap provided by the legislation to manage a number of cases of HIV in the community where individuals were unreceptive or difficult under accepted public health practice and community based norms.

There were over 120 submissions commenting on the 2004 discussion paper. They were generally supportive of the proposed directions for the legislation but there was significant discussion on the principles that reflected the pervasive influence of the new public health in the public health community. As a result a further discussion paper was released in November 2005 that addressed a number of the points raised in the consultations and in submissions that accompanied the consultations. In particular the guiding principles were developed so that they are better able to cover the broad scope of public health practice from environmental health, infectious disease prevention, health protection and health promotion. The first major change was to abandon the principles of "polluter pays "that was seen to be difficult in infectious disease, especially in the light of the recent changes have been adopted regard to HIV/AIDS. Instead the principle of proportionality was proposed which would also sweep up discussion in the previous discussion about not encroaching individual rights.

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[29] review of the Health Act 1958; draft policy paper – for consultation, November 2005

An additional principle to ensure the primacy of prevention in public was proposed. This was to be accompanied by the adoption in legislation of the precautionary principle that was intended to enable public health practitioners and policymakers to adopt preventative or control measures if there were threats of serious public health risk and the lack of scientific certainty. [30] The full list of proposed principles was:

(a) principle full of evidence-based decision-making…
(b) Precautionary principle…
(c) Principle of the primacy of prevention…
(d) Principle accountability…
(e) Principle of proportionality…
(f) Principle of collaboration[31]

The discussion paper also proposed to strengthen the legislative requirements of local government public health through municipal public health plans. This proposal recognised significant developments that had emerged with the release of the Environments for Health policy which had given a policy platform that enabled local governments and local communities to take an active role in public health planning and which was to become an essential platform for the development of later policies around obesity prevention of prevention of chronic disease. The proposal also formalised role of local government in the management and delivery of the immunisation, environmental health and emergency management. All of these roles made local government Victoria very different to that in most other jurisdictions. Arguably, the foresight shown through these policy developments and their legislative formalisation together with the adoption of the principles of proportionality and precaution were among the most far reaching public health reforms in Australia for many years.[32]

Following the release of the 2005 discussion paper the Department was confronted with major public health incident regarding the management of HIV transmission. At the same time there was a growing interest in the prevention of chronic disease, a major focus on diabetes prevention transformed gradually into a focus on obesity prevention. The new focus on prevention both in the area of HIV and obesity saw a strong role for communities through non-government organisations and local government. A review committee was established in the Department to progress almost a decade of work that have been completed on legislative reform, leading to the development of drafting instructions for a new Victorian Public Health and Well-being Act that included most of the 2005 discussion paper proposals and which set the scene for a unique Victorian response to obesity.

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[30] review of the health act 1958: draft policy paper – for consultation, November 2005, p 9

[31] Ibid, p 9-10

[32] The policy environment in Victoria through the Environments for Health policy and developments in immunisation delivery and in partnership developments between Victorian community health centres and local government anticipated many of the characteristics of both the Health in all Policies movement and the healthy cities proposals of WHO.

The Victorian Public Health and Well-being Act 2008 was introduced into the Parliament of Victoria on 8 May 2008 and was the subject of a significant debate. In the second reading speech, the then Minister for Health, Hon Daniel Andrews noted that

> *the introduction of this bill is part of the Victorian government's commitment to promoting and protecting the health and well-being of all Victorians. By repealing the Health Act 1958 and introducing this new bill, we are updating and modernising Victoria's public health framework.[33]*

The Minister placed the new legislation firmly at the centre of Victoria's promotion of a comprehensive national health reform which he noted included shifting the focus to prevention as the first item. The second reading speech made a strong case for the Department of Human Services which incorporated the Department of Health to have a strong enough remit to investigate and manage public health risks "*where the risks of failure are palpable.*"

The second reading speech explicitly stated that the new legislation allowed to the remaking of eight existing sets of regulations and provided for the development of new regulations shall should they be required. The scope of these regulations and the enforcement of the legislation were to lie with Victoria Police and municipal councils.

The minister also stated that

> "*the precautionary principle is included and provides that if a public health risk poses a serious threat lack of full scientific certainty should not be used as a reason for postponing measures to prevent or control the public health risk.*"

This was an important statement in a Parliamentary Forum because it gave significant weight to be implied powers of the legislation, and considerable leeway to public health officials in developing responses to public health threats and incidents. The new act included all the principles that had been outlined in the 2005 discussion paper and which had received strong support in submissions through the consultation process.

The Victorian Public Health and Well-being Act 2008 passed the Parliament with bi-partisan support in August 2008, received Royal assent in September 2008, and took effect on 1 January 2010.

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[33] Victorian Parliamentary Hansard - Parliament of Victoria 8 May 2008 assembly
http://tex.parliament.vic.gov.au/bin/texhtmlt?form=VicHansard.dumpall&db=hansard91&dodr

Outcomes and Aftermaths

In the years immediately following the passage of the Act, Victoria was confronted with a significant number of public health events for which the powers in the act of the principles it espoused proved to be invaluable.

In 2008 a young woman named Clare Oliver began a very public campaign from her hospital bed raising the dangers of artificial tanning and solaria. She had contracted an aggressive melanoma which she believed was a result of her excessive use of artificial tanning. With her death there was a public outcry and media called for additional regulation in the area.[34] The outcome of the event was that solaria were declared non-ionised radiation facilities. The Health Minister announced that the industry's voluntary code of would be included in public health regulations. In fact, the Department of Health developed a set of regulations that encompassed the voluntary code of practice in a way that was consistent with other regulations controlling similar areas. Eventually, they were promulgated under the existing Radiation Safety Act. Even though other legislation was used in the making of the regulations, the regulations that were developed and promulgated had a significant political effect on the government which recognised the power of public opinion in demanding protection and also strengthened the position of public health officials vis-a-vis central government agencies which were strongly antiregulation and deregulationist .

Early in 2009 Victoria experience a catastrophic bushfire event in which 176 people were killed and large areas, many populated, were destroyed. The Act provided the Department and the chief health officer with powers to deploy personnel and resources and to require of local government particular responses in the establishment of emergency management centres. Public health officials immediately commissioned a rapid evidence review of the response.[35] The review provided the Department and other major government entities with a significant evidence base on which to build responses to recovery

In May 2009 a major swine flu outbreak occurred in Mexico that rapidly spread around the world. Victoria became one of the centres of the emerging pandemic and the principles in the act in particular the precautionary principle informed emergency management response. As the epidemiology of the outbreak in Melbourne was analysed the department and its technical partners were able to model and predict the potential spread of the outbreak and to prepare resources and personnel as well as strong communications strategy that enabled the outbreak to be contained.[36]

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[34] http://www.news.com.au/breaking-news/solarium-skin-cancer-victim-dies-from-melanoma/story-e6frfkp9-1111114409318

[35] Hawe, P Community recovery after the February 2009 Victorian bushfires: a rapid evidence review
https://www.saxinstitute.org.au/wp-content/uploads/24_Community-recovery-after-2009-Vic-bushfires.pdf

[36] Kelly HA, Mercer GN, Fielding JE, Dowse GK, Glass K, et al. (2010) Pandemic (H1N1) 2009 Influenza Community Transmission Was Established in One Australian State When the Virus Was First Identified in North America. PLoS ONE 5(6): e11341. doi:10.1371/journal.pone.0011341

In 2010, the National Partnership Agreement on Preventive Health (NPAPH) made available significant resources from the Commonwealth to states and territories to build an evidence-informed response to the burden of chronic disease in the Australian community. The Victorian Department of Health, governed as it was by legislation which recognised the primacy of prevention, the use of evidence in developing policy and a principle based approach, developed an approach to implementation gave a new and leading role to local councils in coordinating local public health action across many health and non-health partners. The support of legislation was invaluable as the system approach that was eventually adopted emerged from the evidence the theory of system science and the co-creation of evidence.[37]

In 2011, Victoria's first Public Health and Wellbeing Plan, developed under the requirement of the Act, was released in Parliament. It reflected a whole-of-government, whole-of-system, and whole-of-life approach.

Conclusion and Reflections

The Act provides a strong example of how well researched legislation can be successful that balances the committee competing demands of the modern economy and successfully incorporates the principles and values of Health in All Policies approach and recognises the social determinants of health and concern for health inequalities.

Many of Victoria's current and emerging efforts to build a whole of government and whole of system focus on preventive health are underpinned and guided by the requirements of the Act, coupled with the leadership of the government of the day. There is a direct line of sight from the Act to prevention and public health in Victoria.

The long gestation of the Act illustrates a number of important points for Public Health practitioners and policy makers. First, policy processes that truly engage stakeholders and the community are complex and by their nature often drawn out and reflect the level of contestability in a Health in All Policies or whole of government approach. Second, the extent of the consultation process and the success of an accepted act that had bi-partisan political support and general acceptance across public health contributed to an environment in which policy leadership and program responsibility could be detached to the extent that is necessary if Health Departments are to be able to convince

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[37] Victorian PreventionCommunity Model, *Healthy Victoria Together*, http://docs.health.vic.gov.au/docs/doc/BB2F0E106F1BFCB3CA2579AA0000EF53/$FILE/Prevention%20Community%20Model%20FAQ%20FINAL%20 feb%2015%202012.pdf

other major partners to accept a level of responsibility for the health outcomes of their areas of responsibility. In Victoria the major expression of health in all policies is the State Public Health and Wellbeing Plan which is mandated in the Act and must be refreshed regularly following elections. The Prevention and Population Health Board, chaired by the Health Department and including senior leadership from across government and other sectors provides a mechanism for formal oversight of developments that affect other portfolios and sectors.

The Act did not mean that specialised legislation and regulation was abandoned and a number of other public health laws remain on the statutes including, the Tobacco Act that governs the Victorian Health Promotion Foundation, the Radiation Safety Act under which solaria and ionising radiation safety are regulated, and the Food Act that was subsequently refreshed and modernised as a companion statute to this Act remain on the statute books.

CHAPTER 8 – CONCLUSIONS FROM THE CASE STUDIES

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<u>Introduction</u>

Six Australian cases illustrate a diversity of intersectoral strategies adopted by governments to address social determinants of health (SDH) and health inequalities. They include top-down political leadership as well as partnership between agencies. They demonstrate different aspects of the policy cycle - including policy development process, policy coordination, and policy and program implementation. They also provide examples of actions at both programmatic and systems levels.

Analysis across the cases can point to similarities and differences, and thus point to factors which might be transferable to other contexts. This chapter provides findings from the cross-case analysis in order to derive key lessons that may be useful for other jurisdictions and interested parties.

<u>Approach to cross-case analysis</u>

The six case studies cover both policy strategies as well as projects, as seen in Table 1 below.

TABLE 1: CASE STUDIES FOCUS

	SYSTEM/GOVERNANCE	TARGETTED GROUP OR ISSUE
POLICY STRATEGY	SA – Health in All Policies TAS – A Healthy Tasmania VIC – Health and Wellbeing Act	Commonwealth – Closing the Gap
PROJECT/PROGRAM		NSW – Housing for Health NT – Strong Teeth, Healthy Bodies

These cases vary in scale. They have arisen from different contexts. Most are relatively recent in their implementation. Despite these differences, cross-case analysis can be undertaken, given the use of similar documentation template, to ascertain what lessons might be drawn from these experiences and offered to future attempts at policy action on social determinants of health.

A thematic analysis is undertaken in the first instance, using the common template, to identify commonalities and differences. These themes are then mapped against a number of other frameworks which have a range of comparable elements, though framed somewhat differently:

- Rio Declaration areas for action: Governance, participation, reorient health sector, global collaboration, and monitoring and accountability
- European Observatory conditions for effective intersectoral governance: Political will, partnerships and constituents' interests, political importance of specific health issue, immediacy of problem, leadership, context, resources, and practicality of implementation

- Building blocks for health system strengthening (HSS): Service delivery, financing, workforce, information, leadership and governance, and technologies
- Health promotion capacity mapping: Policies and plans, core of expertise, collaboration within government, program delivery, partnerships, professional development, information, and financing
- Community systems strengthening (CSS): Enabling environment and advocacy, community networks/partnerships/coordination, resources and capacity building (human, financial, material resources), community activities, organisational and leadership strengthening, and planning, monitoring and evaluation
- NSW capacity building framework: Leadership, partnerships, organisational development, workforce development, and resource allocation
- Best practice framework as enunciated by the Management Advisory Committee of the Australian Whole of Government Project: Culture and philosophy, new accountabilities and incentives, new ways of developing policies, new ways of working, and new ways of designing programs, and delivering services

Finally, shared reflection across jurisdictional members of the project working group provided the strategic analysis of the critical factors that facilitated their work, as well as the key challenges that either had to be overcome or can be expected to continue into the future. From these reflections, the main lessons were drawn for future Australian and global efforts to address SDH.

Key findings

Although the case studies vary in their focus, as seen in Table 1, they share a concern either about health equity or social inclusion, and they all involve multiple stakeholders, either other government agencies or non-government actors. Key themes identified by the policy strategies include: need for high level leadership, importance of stakeholder engagement, value of having a broader policy framework, use of evidence, the importance of political timing, and being able to secure resources. Those case studies focused on projects also pointed to some common themes: transferability of projects, possibility of sustainable change, a focus on clearly identified community problem, availability of expertise, communication strategies, and importance of collaborative process, community participation and stakeholder engagement. In a federalist system, the policy climate at the federal level and the resources made available from the federal government, through recent reforms in intergovernmental relations, also provide an important and shared context for all jurisdictions.

These case studies affirm that the framework for action in the Rio Declaration provides helpful guidance in policy and program development:

- Governance – the importance of interagency partnerships (for policy alignment, program funding), engagement of cabinet committees, use of intergovernmental agreements, and value of legislation (Commonwealth, SA, Tas, NSW, Vic)
- Participation – the critical roles that can be played by civil society coalitions, and the stakeholder engagement that comes with ongoing consultative mechanisms (Tas, NT, Vic)

- Health sector role – health departments provide analytical support for other sectors, advocate for policy development on the basis of evidence, and ensure the health sector also delivers related health programs (SA, Tas, NSW, NT, Vic)
- Monitoring and evaluation – ongoing accountability reporting is crucial, being able to commission evaluation is even more helpful to generate evidence of effectiveness (Commonwealth, SA, NSW, NT, Vic)

The facilitators experienced by these efforts in intersectoral collaboration reflect more closely with the seven conditions for success found in the European Observatory's study on intersectoral governance:

- Government commitment (ie political will) – necessary and existed to provide the authorising environment (Commonwealth, SA, Tas, NT, NSW, Vic)
- Importance of the issue (eg political importance and immediacy of issue) – the right entry points were selected in order to secure commitment (Commonwealth, NT, NSW, SA, TAS)
- Leadership - champions and policy entrepreneurs who also had strong networks across and outside government agencies were in place and mobilised support (Tas, SA, NT)
- Partnerships – needed and were established within and beyond government, with non-government organisations playing important roles in advocacy and resource mobilisation (Commonwealth, Tas, NT, SA)
- Resources – human and financial resources were committed (NSW, NT, Commonwealth)
- Practicalities of implementation –tools such as Health Lens and Health Impact Statement were available to be applied (SA)
- Context – possible to leverage broader public policy frameworks and developments (SA, TAS, Commonwealth) and link with existing related programs and systems (NT, Vic)

In the context of a federation, where responsibilities for financing and program delivery may involve two or three levels of government but with the roles split differently across portfolios, obtaining government commitment is both particularly important as well as challenging. The role of local government, constitutionally being the creation of states, is also diverse, and dependent in part of the philosophical orientation of state governments. Thus securing authorising environment for intersectoral partnerships with local government, as seen in the Victorian case study, takes considerable time and effort.

In addition to those factors identified by the European Observatory studies, these case studies also suggested the importance of building on history (given the public health principles, narrative and advocacy coalitions have developed since the 1980s), and the extent to which having a shared vision or being able to articulate co-benefits helped facilitate collaboration and commitments. In Victoria, the historical relationship between state and local governments in public health practice, and the strength of public health ideas (such as precautionary principles, community participation, and the primacy of prevention) were important foundations for legislation that formalised the authorising environment for intersectoral action. The Tasmanian case study further underscores the significance of advocacy from the community sector in order to secure political importance.

By the same token, when these factors or conditions are not present, then substantial challenges exist in trying to effect intersectoral policy collaboration. In the context of a decentralised,

geographically dispersed, and federalist system, there may be considerable difficulties in achieving policy alignment across different levels, assuring intergovernmental financial transfers are well targeted, and securing bipartisan political commitment to action on health inequalities. Strategic thinking and policy entrepreneurship is needed in the health sector in order to navigates across such complex public policy spaces.

Successful intersectoral policy advocacy and program development ultimately rests with two capabilities that the health sector – within and outside government - need to have. Firstly, the health sector needs to take responsibility for drawing attention to the social determinants as a lens for addressing wicked problems. Secondly, health sector also need to provide leadership for intersectoral action on the social determinants by demonstrating how to apply a health promotion framework to tackling wicked problems. These capabilities develop when the building blocks of a health promotion system is in place.

The analysis of the case studies in accordance with the health promotion capacity mapping framework shows that, to a large extent, the building blocks of a health promotion system can be seen across the jurisdictions represented in these cases. In other words, these jurisdictional did have in place the foundations of a strong health promotion system, including:

- Policies and plans – these are the products of intersectoral governance and basis for joint action; intersectoral planning (eg municipal public health plans) can also be prescribed (Vic)
- Expertise – analysis of health impacts and evaluation of outcomes offered by the health sector (SA, NT, NSW) and generally evidence about effective public health measures for prevention (Vic)
- Collaboration within government – seen through policy development and program delivery (Commonwealth, SA, NSW)
- Partnerships with non-government actors – important for building constituency and political momentum as well as for program delivery (NT, Tas, Vic)
- Financing – programs require funding commitment (Commonwealth, NSW, NT)
- Program delivery – a variety of program delivery vehicles have been adopted (Commonwealth, NSW, NT)
- Information – policies and programs have drawn on a range of evidence for their development and monitoring mechanisms are in place (Commonwealth, SA, Tas, NSW, NT)

Such foundations are not built overnight, and the renaissance of public health since the 1980s in Australia, through institutional building and experience in design and delivery of a myriad of national public health programs, would have been important in fostering these system capabilities. Thus, there is a cycle of understanding evidence and ideas, translating them into action, learning from the experiences, and applying them to new health issues. It is through this iterative testing and learning process that new ideas become accepted and then embedded into the practice of public health and public policy.

As these case studies have not focused on the internal workings of the organisations involved in policy and program developments, it is not known what the human resource capabilities are like and the extent to which professional development (being one of the domains of health promotion system capacity) was required or undertaken. However, it is possible to surmise that the existence

of these building blocks, including human resource capabilities, have been developed in the health sector over the last two decades, since the renaissance of Australian public health began in the 1980s.

St Pierre and Gauvin (2010) suggests that organisational culture is also a key condition for effective intersectoral governance, and point to capacity-building, reshaping of values, and collective learning mechanisms as strategies for culture change. The reshaping of values is likely to be a long-term proposition for Australian jurisdictions, however, having mechanisms that bring diversity of stakeholders together can start the process of collective learning. The extent to capacity-building for other sectors was and/or needs to be part of the policy advocacy and partnership process warrants further reflection.

The cases can also be mapped against the best practice framework of the Management Advisory Committee for the Australian Whole of Government Project, depicted in Figure 1 below:

FIGURE 1: BEST PRACTICE FRAMEWORK

SOURCE: Management Advisory Committee. 2004.

Without detailed information about the inner workings of health departments and their relationships with other agencies and non-state actors, it is difficult to conclude that any of the case studies comprehensively reflect best practice. Nonetheless, elements of these best practice domains can be found in most of the case studies. The system-wide efforts of SA, Tasmania, and Commonwealth capture most closely best practice features. The valuing of whole of government approach and alignment of top-down and bottom-up reflect a philosophical and cultural orientation. Having shared leadership, incorporating expertise, points to new practices. A collegiate process focused on shared outcomes and engagement with stakeholders point to new policy processes. Many of these features can also be seen in focused programmatic interventions, such as in the NT.

<u>Main lessons</u>

Experiences gained in both policy development and implementation (Commonwealth, SA, TAS) and program development and implementation (NSW, NT) all provide lessons for intersectoral collaboration to address social determinants of health. The Victorian Health and Well-being Act shows how intersectoral action can be secured through legislation and become a mainstream practice. Together, these case studies illustrate how to move from an idea for solving a problem to creating the authorizing environment for intersectoral action and finally to how a sustainable, enabling environment might be created. All case studies point to the value of utilitarianism, in choosing the appropriate entry point for attention and action, and in providing the appropriate framing of the policy problem and the policy solution. They also point to the importance of not losing sight of the public health principles and values.

When considering each case study and looking across the case studies, it is possible to see the degree to which context and agency both matter, the importance of policy and political context, the degree to which there is a shared understanding of mutual benefit, the importance of relationship management, the way in which history lays important foundations for both framing and understanding of issues as well as the way networks operate.

Of the cases, the NSW program has been in operation for a substantial length of time and the evaluation has shown clear health benefits from addressing housing issues. A major evaluation is also in train for SA on the HiAP experience. As other policy strategies or programs are still in relatively early stages, there is scope for greater attention to be given to monitoring and evaluation. This will ensure not only public accountability but also help contribute to the evidence base on what approaches are effective in addressing social determinants of health. Given the methodological challenges in evaluating complex interventions in relation to specific health outcomes, being able to demonstrate a variety of intermediate outcomes – such as problem-solving capacity, health literacy, social connectedness, etc - is particularly important.

Reflecting on the collective experiences of policy development and program delivery, the lessons across the six Australian case studies point to:

- The authorising environment is crucial, to give permission for policy innovation and for horizontal governance to survive and thrive,
- Pragmatic incrementalism means taking a small step when the opportunity is presented, and with small successes come further opportunities.
- Tying to fit in existing systems hold better promises for embedding sustainability and transferring learnings across systems.
- Champions are needed, but they also need to be supported by active networks and strong coalitions.
- Challenging policy concepts and practices can be operationalized if there are practical tools that can be applied across a variety of problems.
- There are no prescriptions for solving wicked problems, but intersectoral governance can create the enabling environment for state and civil society actors, and help embed policy and program learnings and ensure their sustainability.

Beyond these process lessons, a further lesson arising from these case studies is that demonstrating the possibility and success of intersectoral policy action can help policy makers understand better the impact of their work on population health and health equity. Such political and high level bureaucratic attention can be important in improving public health efforts to work across sectors. Certainly, Closing the Gap illustrates how important it is to embed the thinking about intersectorality into all parts of government if change is to be achieved for the longer term.

Implications for the future

The six case studies are but a small part of the efforts from Australian governments to address health equity through action on the social determinants of health. It would be possible to point to social and economic policies that are likely to have a positive effect without being labelled as action on SDH. Similarly, there are other activities in the health and community service system, in existence for the short and long term, that contribute significantly to addressing health and social inequities.

However, in looking at these case studies, with their early achievements, some suggestions for the future could be offered. Strengthening the evidence base is needed, though evaluation methods for complex interventions are underdeveloped. Health promotion interventions typically adopt a multiplicity of strategies, so the attribution of cause and effect is difficult, especially as each action alters the context, which in turn requires further adaptation of intervention strategies to the changing context (Pawson and Tilly 1997). Joined-up policy adds another layer of complexity, and policy appraisal is made difficult by the length of time to produce measureable health outcomes. More action research to accompany these policy efforts can contribute to ongoing course adjustments, while more attention to evaluation would help build a stronger evidence base for the future. Ensuring current surveillance systems are able to capture inequalities and social determinants of health would provide the information infrastructure needed for policy evaluation. Developing a mechanism for cross-jurisdictional policy learning would help accelerate transfer and scaling up of current efforts.

Given early positive experiences, it is important to plan for 'scaling up' as well as sustainability. Australia, like other developed countries, is facing long term resource challenges related to aging and NCDs. With NCDs receiving national and global political attention and the UN Declaration on NCDs, a national partnership approach, in the Australian context, would bring together in a coordinated fashion the policy interventions to address key risk factors (ie tobacco, alcohol, diet, physical activity, obesity). At the same time, further development of settings- and population-based interventions (ie health communities, healthy children, healthy workers, and Closing the Gap) in a synergistic and place-based fashion could provide for flexibility in resource allocation and support better system integration while retaining a focus on key health and social outcomes.   Such an approach could incorporate intersectoral policy action on social determinants for NCDs and secure partnership across government departments as well as between government and civil society.

The challenge for Australia, not unlike other countries, remains the nature of the political system, and health politics in particular, as well as the nature of public administration. The sectoral structure of public service is both necessary as a way of having management boundaries as well as a barrier for addressing cross-cutting issues. In addition, coordination in a federalist system is always demanding, and this is exacerbated by short political cycles in all jurisdictions. The funding and

operation of the healthcare system, particularly hospitals, periodically dominate political debates and shape the fortune of political parties. This strife of interests tends to take policy attention away from longer term stewardship of the health of the community. From this perspective, there is a need to improve awareness of social determinants of health not only within government programs, but also amongst health and community service providers and in the community more generally.

In times of fiscal restraint, it becomes all the more urgent for the health sector to provide the business case, through analysis and modelling of intervention options, to demonstrate the intimate link between good health, productive economy, and cohesive society, and how a coordinated approach across government is both efficient and effective (Lin 2010). However, given health is co-produced by individuals, community organisations, businesses, and government services, a whole-of-society approach is needed to accompany a whole-of-government approach. Governments will need to consider how to provide stronger incentives to promote corporate social responsibility from the business sector, locality development in socially and economically disadvantaged communities, and improved access to products and services that maintain health and well-being.

Policies are essentially natural experiments. There is value for further research in tracking intersectoral policy processes – including governance structures and governance actions – and changes in SDH and social and health inequities. Such research would contribute to improved arrangements for horizontal governance if not more effective policy interventions. Better evidence, including evidence from economic evaluation, would support collective learning and adjusting the course of policy implementation. It would also help to shift from innovation at the margins to sustaining, embedding, and systematising good intersectoral policy making.

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