#SDOH

Acting on the social determinants of health – for a fairer distribution of health

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Croakey.org is releasing this compilation of articles to mark the 57th Boyer Lecture series by Professor Sir Michael Marmot.

Sir Michael is President of the World Medical Association, Director of the UCL Institute of Health Equity and has been a leading researcher on health inequality issues for more than four decades.

These are a selection from more than 1,030 articles on the social determinants of health that have been published at Croakey between 2010 and 2016

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Introduction: "Do something, do more, do better"

To commemorate the 57th Boyer Lectures Series, delivered by Professor Sir Michael Marmot, with a focus on reducing health inequality, Croakey has compiled a selection of some of our related coverage over the past several years.

Here are some of the reasons why you might like to read these 25 articles.

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Professor Sir Michael Marmot, *Director, Institute of Health Equity, UCL Department of Epidemiology and Public Health, London*

When it comes to health, Australia shows the best and…if not the worst…at least, the shameful – the Indigenous non-Indigenous health gap. But in the non-Indigenous population, too, there is a social gradient in health. Solving these health inequalities requires action on the social determinants of health. Croakey has been a force for good in bringing to the fore the kind of actions that are needed. Remember the message of European Review: do something, do more, do better.

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Professor Fran Baum, *Matthew Flinders Distinguished Professor Director, Southgate Institute for Health, Society & Equity Southgate Institute for Health, Society & Equity, Flinders University*

It's ten years since the Commission on Social Determinants of Health first met and the articles in this compilation are representative of the relentless advocacy since then to put social determinants and health equity on the Australian policy agenda. There's been mixed progress. The most impressive has been the effort of the Aboriginal health advocates who have ensured that the Australia's National Aboriginal Torres Strait Islander Health Plan (2013-2023) is based on the social determinants of Indigenous health. Other health policy would do well to follow this lead as our research shows that most doesn't take action on social determinants. Our biggest challenge is to ensure all policy sectors are held accountable for their health impact. This is where the big gains for health equity are to be made. Health impact assessment, health in all policies strategies, Healthy Cities initiatives and the like will help us move along the road Sir Michael will promote in his Boyer lectures. Let's hope our policy makers and political leaders listen carefully to his messages and realise that it is in their power to make health equity a reality in Australian within a generation.

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Dr Tim Senior, *a GP working in Aboriginal health, and #WonkyHealth columnist*

Our health services provide valuable services, but they do not provide health. Our health services help us manage our diseases and make sense of our illnesses, then put us back in the conditions that make us healthy or unhealthy.

Health is not a commodity, bought and sold. Health is not consumed. Health does not come in the shape of pills or lotions or medicines, even alternative ones.

Health is something that happens when our air is clean, our water is clear and our food is fresh. Health happens when we are treated well at school and at work. Health happens when we can control our own lives and be accepted for who we are. Health happens when we have friends around us.

In short, health happens when we are loved and our world is beautiful.

None of this happens in a vacuum. The way we do business affects our health. Government policies create the conditions for us – ideally, all of us - to be healthy. Create those conditions correctly, and we have flourishing, healthy people in a flourishing, healthy economy.

Creating those policies belongs to no single profession and no single political party. We need individual freedom and opportunity, safe workplaces and protected environments to be healthy.

So, whatever you are interested in, you are interested in health. Read this collection of essays from Croakey – the only website in Australia routinely discussing these issues.

Read it because, to misappropriate Prof Michael Marmot's words, "We are all health ministers, now."

My health is in your hands.

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NACCHO

NACCHO encourages the Commonwealth to recognise that the social determinants of Aboriginal and Torres Strait Islander peoples and their ensuing health inequities are significantly influenced by broad social factors outside the health system. NACCHO asserts that the Commonwealth is well positioned to identify those factors and act upon them through policy decisions that improve health – supported by current evidence – in housing, law & justice and mining & resource tax redistribution, for example.

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Sharon Friel, *Director and Professor of Health Equity, School of Regulation and Global Governance (RegNet), College of Asia and the Pacific, Director, Menzies Centre for Health Policy, The Australian National University*

Almost 10 years ago the Commission on Social Determinants of Health, chaired by Sir Michael Marmot, noted that the unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but isthe result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. The same is exactly true today and very much the case here in Australia.

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Please note that many of these articles were first published some years ago. The authors and people mentioned in them may not be in the same roles or positions.

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Poverty, inequality and power

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Rise & be heard: Joining forces to ask questions, demand answers on poverty – and to be shown some respect

Introduced by Marie McInerney:

US author and poverty campaigner **Linda Tirado** was at college and working in two low-paid jobs in the United States when she wrote **this post** on what it's like living hand to mouth in a wealthy country. It went viral and, as *Late Night Live* described it, she went from night shift diner cook to speaking at the London School of Economics. She wrote Hand to Mouth: The truth about being poor in a wealthy world – and last year delivered the keynote address at the Australian Council of Social Service national conference.

Her post struck a powerful chord – but she was also subject to **vilification and overwhelming scrutiny** of her personal life, from her welfare records to the state of her teeth.

Back in Australia two months ago for a visit, she saw a similar wave of fury and contempt roll with devastating impact over **Duncan Storrar**, the man who 'dared' ask a question on the ABC's *Q&A program* about equity in the Budget and ended up with his life laid bare on morning TV shows and **labelled a villain** on the front page of the Herald Sun.

As **this story** in *The Age* outlines, Tirado delayed her return to the US and now she and Storrar have joined forces to create the **Rise And Be Heard** project, which invites people to pose questions to politicians online which the project will then seek to have answered.

She wrote this powerful post for Croakey below on what it's like to be subject to such a full frontal "outpouring of hatred and bile" and the risk that it silences those who have the most right and need to speak up. She says:

> *There is a human cost to every bloodless policy drafted by the people who decide our futures. Those who will pay it should be first at the microphone, because it will be paid in our sweat, our lives, our happiness.*

See the bottom of the post for a call to action. You can follow the project on Twitter at **@riseandbeheard** and Linda Tirado at **@KillerMartinis**.

Rise & be heard: Joining forces to ask questions, demand answers on poverty – and to be shown some respect

Linda Tirado writes:

I don't know how to write about becoming not-quite-famous. I've been considering this problem for weeks now, ever since I watched Duncan Storrar be publicly eviscerated. The nightmares came back in full force, though they'd not become so infrequent that I was shocked by them.

I woke this morning surprised to find myself in a bed; I had only moments before been tied to a stake naked in the public square while the morning shows reported on my every flaw and strange masked men walked by hissing twisted threats at me. Another frequent dream involves my being forced at gunpoint away from the cash register I used to work at, put into a bag, and beaten by unknown assailants for however long it takes until I wake up. The nightmares are like old toxic lovers now, comfortable in their awful familiarity.

Nearly three years later, I've got the panic attacks under control to the point that I can keep talking to people while they happen; I've learned to simply explain that my body sometimes gets shaky and weepy and that there's nothing actually wrong with me and anyway what were we talking about?

I have trouble with reality sometimes. It's such a fungible thing; once, I went to sleep with my infant daughter and I woke up notorious. My life since then passes in great whomping gulps of time; sometimes I have dinner on sparkling rooftops overlooking Darling Harbor and sometimes I sleep rough in London for a story and sometimes I'm a mother of two and sometimes I'm on TV talking about the news and then I know that I am myself shaping reality and it's all a bit too much for one human brain to puzzle out.

What I know is that I'm not exactly human anymore, not in the way I used to be. I check in and out of humanity, really. I have lost something indefinable, and it makes me incapable of dealing with people for too long before it gets overwhelming and I have to hide for weeks or months.

It's a peculiar thing, having your privacy stripped away from you. Nobody bothers to ask your consent, you know. They talk about you and then, because they've talked about you, you're a public figure, so you can't call it harassment.

It's a heart-stopping lack of autonomy, waiting for the dust to settle so you can see what shreds of a life you might be able to eke from the wreckage. At a certain point, you become the entertainment of the week as people who didn't know you existed ten minutes ago and have now read a few hundred words about you (written by other people who have never spoken with you) debate your relative morality, your worth as a human being, whether you should have had children, whether you deserve to eat, whether you should even be breathing today.

I thought about all this as I paced frantically a few weeks ago, having heard that Duncan was on suicide watch and wondering whether the Australian media – both traditional and social – had just killed a man for clicks.

Rise & be heard: Joining forces to ask questions, demand answers on poverty – and to be shown some respect

And over what? I said it sucked to be poor. Duncan said the same, though more intelligently than I'd managed. "Being barely able to make it isn't a pleasant way to live your life" isn't, to my knowledge, a particularly controversial statement. So it's not what we said.

But then, why the unprecedented outpouring of hatred and bile, the journalistic hours lost to coverage of what should be a non-story when there was actual news happening? There are people dying on an island not far from these shores, killed in the name of every Australian and the news was that a rough man with a rough life asked a question about taxation?

The lesson the "news" left us with: if you want to have an opinion, you'd better have a life that's camera-ready. Otherwise, whatever joy or small comfort you've scraped together will be destroyed along with any hope for a future – and then they'll start in on your family.

On the eve of the election, the most eloquent and necessary voices on the subjects of welfare and unemployment and the challenges of the single parent or the permanently disabled – people who've never gotten far enough ahead for perfection – were made to seriously consider whether they'd want to volunteer for what I, and Duncan, lived through. Whether they could even make that decision for their own families.

Millions of people across Australia got the message loud and clear – this place is not for you.

The message is wrong.

This place is for everyone, or should be if Australia can live up to its best future. This place, where we honour the rightful owners of this land but never seem to find a way to share it with them, this beautiful island where the homeless are cleared from the streets before the sun can expose them to public view, this lucky country that now considers cutting disability pensions because luck means never having debilitating trouble with your body –- this place still holds more promise than most.

This place is for the wealthy and the beautiful and the well-educated, and also for the people who clean their homes and maintain their places of commerce. This country where the birds always sing is for the people too busy to enjoy the songs, for the people who've been looking for work for too long, for the ones who have been so beaten down for so long that they can barely muster the will to care for themselves.

I am frequently described as angry. That isn't the right word. I am livid, nearly boiling over with the pain of thousands of people I have spoken to over the last years. They all have their own way to phrase the question but it always comes down to: why don't I matter, too? Why isn't my future as valuable as anyone else's? It is plaintive, small, a hurt so keen that we never say it exactly aloud.

It's time to say it. Not to ask the question, but to demand the answer.

There is a human cost to every bloodless policy drafted by the people who decide our futures. Those who will pay it should be first at the microphone, because it will be paid in our sweat, our lives, our happiness.

There is poison in silence, which never equals consent but usually gets confused for it. We are allowed to ask questions, we are allowed to get above our station, we are allowed to be impertinent in the face of Wrong. And what else do you call it, when single mothers can joke about losing weight on the Newstart Diet and people who need lifesaving medical care aren't sure their own government won't cut that program?

Can it be anything but wrong that people feel afraid to speak while they eat their democracy sausages?

If you'd like to get involved in the project, it's easy: think of a question you'd like to ask. Submit it at **www.riseandbeheard.com** *or send us a picture* **through Facebook** *or on Twitter at @riseandbeheard. Retweet, repost, pass the link around. We'll be collecting questions across Australia and posting answers we get back from newly seated MPs. It's time to rise, and be heard.*

Stand up. Speak out. Never silent.

International conference puts spotlight on corporate power as a health threat – and calls for Health in All Policies

Introduced by Melissa Sweet:

Corporate power is one of the major barriers to improving global health, according to **Dr Margaret Chan**, the Director General of the World Health Organization.

In **a strong opening address** to the **8th Global Conference on Health Promotion** in Helsinki, Finland, Dr Chan also highlighted concerns about inequalities, between and within countries, which "are now greater than at any time in recent decades".

"We increasingly live in a world of rich countries full of poor and sick people. The rise of noncommunicable diseases threatens to widen these gaps even further," she said.

Efforts to prevent noncommunicable diseases go against the business interests of powerful economic operators, she said, and "this is one of the biggest challenges facing health promotion".

Dr Chan said public health did not only have to contend with Big Tobacco:

> *Public health must also contend with Big Food, Big Soda, and Big Alcohol. All of these industries fear regulation, and protect themselves by using the same tactics.*
>
> *Research has documented these tactics well. They include front groups, lobbies, promises of self-regulation, lawsuits, and industry-funded research that confuses the evidence and keeps the public in doubt.*
>
> *Tactics also include gifts, grants, and contributions to worthy causes that cast these industries as respectable corporate citizens in the eyes of politicians and the public. They include arguments that place the responsibility for harm to health on individuals, and portray government actions as interference in personal liberties and free choice.*

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" *This is formidable opposition. Market power readily translates into political power. Few governments prioritize health over big business. As we learned from experience with the tobacco industry, a powerful corporation can sell the public just about anything.*

Let me remind you. Not one single country has managed to turn around its obesity epidemic in all age groups. This is not a failure of individual will-power. This is a failure of political will to take on big business."

Dr Chan said WHO believed that the formulation of health policies must be protected from distortion by commercial or vested interests.

"When industry is involved in policy-making, rest assured that the most effective control measures will be downplayed or left out entirely," she said. "This, too, is well documented, and dangerous."

Health in All Policies (HiAP) was the theme of the conference, and **some interesting insights** emerged about what can help facilitate such approaches.

Presentations highlighted the importance of central leadership (heads of government rather than health ministers are best placed to lead HiAP), regulation, and an HiAP workforce with the ability to negotiate complexity, to facilitate social change, and to create conditions that promote favourable political decisions.

The invitation-only conference was co-organised by the World Health Organization and the Ministry of Social Affairs and Health of Finland.

Below is a wrap of some conference highlights, including an article from **Professor Fran Baum** reflecting upon the implications for Australia. Beneath her post are summaries of some key presentations.

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Lessons from Helsinki for local, state and federal governments

Fran Baum writes:

As the conference came to a close, I've reflected on the main lessons for Australia.

The first message is that health and its distribution (health equity) should stand alongside GDP as a measure of how well a society is doing.

This was also the message from the Commission on the Social Determinants of Health whose relevance to Australia has been reinforced by the **Senate Standing Committee on Community Affairs**.

International conference puts spotlight on corporate power as a health threat – and calls for Health in All Policies

Health in All Policies is a vital mechanism to implement action on social determinants and is one that should be adopted by local, state and the Federal government.

Australia has some history of doing this through Healthy Cities projects and a formal Health in All Policies initiative in South Australia. The consensus feeling was that Health in All Policies should be lead from the Head of Government (Mayor, Premier or Prime Minister) but that the health sector has a vital technical support role.

Health promotion matters

A crucial stand out message for us from Helsinki is: why on earth are our state governments cutting back their spending on health promotion?

This conference over and over again stressed the need for all health systems to have a strong health promotion effort and that Health in All Policies was one part of this but that local health promotion through primary health care is also vital.

Yet both South Australia and Queensland have been busy making very significant cuts to their health promotion effort.

It is particularly strange for South Australia, which has such a strong record in the area and whose Health in All Policies work has been recognised internationally and at this conference. Luckily HiAP in SA appears to have survived the cuts so far.

Australian governments should be aiming to increase their investment in health promotion. Over and over again the economic sense of this investment was stressed.

For instance, if we don't ensure that all children have a healthy childhood then the whole of society will bear the future costs through the health, criminal justice and welfare sectors.

For Australia to make cuts to health promotion at any level of government is long-term economic madness.

Standing up to industry

There were also key lessons about dealing with the impact of industry on health.

The adverse consequences of Big Food, Big Soda and Big Alcohol were laid out plainly by WHO Director General Dr Margaret Chan when she said:

"In the view of WHO, the formulation of health policies must be protected from distortion by commercial or vested interests," whose tactics "include front groups, lobbies, promises of self-regulation, lawsuits, and industry-funded research that confuses the evidence and keeps the public in doubt."

Frances Fitzgerald, the Irish Minister for Children and Youth Affairs, also talked of the need to make the lobbying tactics of industry transparent and to ensure that health promotion advocates have the same access to politicians as industry representatives.

It is so easy for industry to paint their influence as benign and even helpful to health while ignoring adverse health impacts (including tax evasion).

International conference puts spotlight on corporate power as a health threat – and calls for Health in All Policies

A representative from the World Economic Forum made such a presentation and I tweeted (@baumfran) it as a "healthwash" akin to the dubbing of questionable industry environmental credentials as "greenwash".

These issues of industry conflicts of interest are issues we need to tackle in Australia to ensure that the political influence of industry is not working against health.

Delegates spoke of the need for industry regulation and the importance of dealing with the ideological battle whereby measures to protect health are derided as the "nanny state" in action and as interfering with individual rights.

Australia was congratulated at the conference for its tobacco plain packaging legislation and there were frequent references to the ways in which industry have tried to undermine it.

There was also much discussion about the post-2015 Millennium Development Goals agenda and a strong feeling that the Health in All Policies approach is very relevant.

Health equity and development

Over and over again delegates stressed that the post-2015 agenda had to include health equity as a goal and pay attention to the very real differences in health status within countries.

The structural unfairness of the world's economic system was also discussed and there were calls for it to become fairer and increase regulation for global public health.

The final session included a call for development assistance budgets of rich countries to be at 0.7% – an important message for Australia.

The **final conference statement** was strong on recognition of the problems HiAP faces, yet disappointingly weak in terms of its recommendations. This was especially true given DG Chan's powerful opening speech.

In response, a group of us from the People's Health Movement are working to develop **a stronger Call to Action**.

Australia could benefit by considering our recommendations on the importance of progressive taxation, on the need for Health in All Policies to be led by heads of government in order to eliminate the policy incoherence that undermines population health and exacerbates health inequities, and the need to regulate other health-damaging industries in the way we have tobacco.

Overall, the 8th Global Conference on Health Promotion has greatly reinforced the absolute importance of concerted government action to ensure that the conditions of our everyday lives – at home, work and in our communities – as much as possible create supportive environments for health.

Far from being the actions of a "nanny state", this is the way in which the right of all of us to be as healthy as possible is realised.

International conference puts spotlight on corporate power as a health threat – and calls for Health in All Policies

• Fran Baum is a professor of public health. She is the director of the Southgate Institute of Health Society and Equity, Flinders University, Adelaide, Australia, and is a member of the Global Steering Committee, People's Health Movement. She is an Australian Research Council Federation fellow. Follow her on Twitter: @baumfran

Here is Fran Baum's presentation on the evaluation of HiAP work in SA, where Health in All Policies has been promoted as a strategy to address complex problems and has strong across government support. She said that implementation is mediated by organisational culture, capacity and priorities, power relationships, political will and resources.

Fran Baum also blogged for the BMJ on the conference:

On Finland's primary healthcare system which provides free accessible multidisciplinary primary healthcare services to all its population, the need to use fiscal measures to control risk factors for chronic disease, and an observation that "failed childhoods are very costly to society".

On how governments can get Big Food to stop addicting us to sugar and fat (and what we can learn from Finland on this re the importance of regulating the food supply, and from Thailand's approach to HiAP and progressive health policies)

On Ecuador's impressive progress on health and social spending, and reducing inequities through multisectoral action. The conference also heard Canadian Greg Taylor cite Danny Broderick, senior policy officer in HiAP, South Australia as saying "Intersectoral action can sometimes be like a tug of war. HiAP has different logic—let go of the rope."

On the globalisation of unhealthy lifestyles and suggestions about how to create the political will for HiAP.

Perhaps at least some of the answer lies with whether the public health community can effectively engage the general community and wider health sector (perhaps via social media et al) in creating political pressure for change.

How inequality creates complex health and policy challenges

In the fourth edition of his **crowd-funded** **Wonky Health** column, Dr Tim Senior examines evidence from around the world about the health needs of disadvantaged peoples, reporting that poorer people tend to develop more complex medical problems and at a younger age than richer people.

While this is a critical area of policy that needs addressing, he cautions:

" *… the solutions may not be the ones we think they are. If we're making policy, we're employed with a computer on the desk in front of us, and another one waiting for us at home. We have a high degree of choice in our lives and usually aren't confronted with as many mental health, drug and alcohol problems and chronic pain as those we need to be thinking about.*

In other words, the solutions we come up with are those that would work for us. These may be not just the wrong solutions, but solving the wrong problems."

Tim Senior writes:

If you're worried about the aging population, and what that means for our health system, then you need to be worried sooner about inequality. Here's why.

Wonky Health

It's generally recognised that as people get older, they have more medical conditions, and together these are more complex to manage. They require more services and more professional help.

Our health services (not to mention social services) will have to work out ways of providing this. And as a society we will have to work out how to fund it.

In the field that I work in, Aboriginal and Torres Strait Islander health, we recognise that on average people have more medical conditions at a younger age. Often Aboriginal and Torres Strait Islander people become eligible for services for older people from the age of 55, where it is 75 for non-Indigenous people.

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How inequality creates complex health and policy challenges

The reason for this is not that they are Aboriginal. **It is not due to genetics**. It is due to the fact that Aboriginal and Torres Strait Islander people are over-represented in those sections of our communities who have been excluded from the main workings of our society and do not have access to social goods.

There are specific historical and cultural aspects to our society's exclusion of Aboriginal and Torres Strait Islander people, but just the fact of exclusion has an effect.

A team of health researchers in Glasgow have done a lot of work in this area. **They show** that while multimorbidity is more common in those older then 65, more than half of those with more than one medical condition are younger than this. What's more, they show that the poorest group in society has 2 or more medical conditions 10 to 15 years earlier than the richest group.

So while we are grappling with the complex services required for the elderly, those in underserved communities will need these services 10-15 years earlier. A rough guess might suggest that time is now!

Certainly, **evidence from this research group** and from Aboriginal **Medical Services** in Australia shows that the effect on primary health care is that longer consultations are required dealing with more problems at each visit. More professionals are involved for each patient.

But it's not enough just to think that not having money is just the same as having money without the designer goods. For example, offering everyone health checks (leaving aside the fact **they don't work**) is a nice middle class solution that attracts middle class people to health services they can already access. It **doesn't attract those who might really benefit** from preventive care.

Three recent papers put some interesting meat on this. First of all, the same group of researchers showed that not only did the presence of multimorbidity come in at a younger age for the socioeconomically deprived, but the **types of conditions they suffered from were different**.

There was much more anxiety, depression and drug and alcohol problems in deprived communities, which is perhaps unsurprising. There were also higher rates of chronic pain – think on that! – as well as dyspepsia, coronary heart disease and diabetes.

You can imagine from this the sort of services that will be required in these areas. Drug and alcohol and pain clinics aren't very sexy, though, and rarely get people out on sponsored fun-runs. They are also treatment areas that don't provide simple solutions.

It's easy to think people should just make more sensible choices about their lifestyle. **Another recent paper** looks at preventive advice and activities in lower-income compared to higher-income individuals.

The survey was done in Canada so some of the findings may have not translate directly to Australia, though personal experience would not suggest it is hugely different here. They found that preventive health advice, such as smoking cessation, dietary changes, and exercise were offered equally by health professionals regardless of income.

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However, they found that people on low-incomes were less likely to stop smoking, and less likely to have a cholesterol or glucose test. The reasons for this were more often due to extrinsic factors beyond the person's control in lower income individuals, such as cost or availability. Higher income individuals were more likely to say it was due to personal choice.

The **third study** comes from America and looks at the use of e-health activities. They found that the biggest predictor of whether someone used e-health or not was their socio-economic status.

Older men and those on low incomes or lower levels of education were less likely to use the internet to look for health information, or to find or communicate with a doctor, let alone use computers to track their own information. Again, this is America, but there is evidence of a digital divide in Australia, and I'd be surprised if these findings were completely different here.

Policy implications

What does this mean for the development of policy?

First of all, it means that the multimorbidity and need for complex services that we are expecting as the population ages is already here for the worst-off sections of our society.

Second, it means that the solutions may not be the ones we think they are. If we're making policy, we're employed with a computer on the desk in front of us, and another one waiting for us at home. We have a high degree of choice in our lives and usually aren't confronted with as many mental health, drug and alcohol problems and chronic pain as those we need to be thinking about.

In other words, the solutions we come up with are those that would work for us. These may be not just the wrong solutions, but solving the wrong problems.

Fortunately there is some more evidence for an age-old remedy that works – engage! **This paper** looks at health reform in Australia and suggests that if we want equitable health care in Australia – and I would firmly suggest we do – then we need to think about equitable governance. This is policy-speak for involving those who need the service in the planning and running of the service.

Clearly, Aboriginal Community Controlled Health Services show a way of doing this in Australia. They have **demonstrated excellent outcomes** in populations that are often described as difficult, high risk and hard to reach. That's only true when you ignore their needs!

The paradox here, of course, is that while the health sector worries about an aging population, the Aboriginal health sector is seeing too many people die before they reach retirement age.

There really is no time to lose for any of us.

Tim Senior and Croakey thank and acknowledge all those who contributed to the crowd-funding campaign to support Wonky Health – more details here.

This link compiles Wonky Health columns.

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Children's health

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How Australia is failing our children – reports from Caring for Country Kids conference

PUBLISHED: **April 25, 2016**

BY: **Melissa Sweet**

Seismic changes are needed in policy-making and service delivery to ensure a healthier early start for children, particularly for those growing up in poverty and disadvantage.

This was one of the strong themes from compelling presentations to the **Caring for Country Kids Conference**, which was jointly organised by Children's Healthcare Australasia (CHA) and the National Rural Health Alliance (NRHA), and held in Alice Springs.

Australia needs the bold, visionary thinking of a "Snowy Mountains scheme" for children and families, to disrupt existing systems and to improve policy and services for children and families, paediatrician **Professor Frank Oberklaid** told the conference.

Similarly, the University of Melbourne's **Professor Kerry Arabena** called for "radical transformation" rather than incremental change, and for a move away from "monocultural" thinking.

Conference participants also heard a powerful presentation from Alyawarre woman **Pat Anderson AO**, the chair of the Lowitja Institute, on the devastating impacts of policy failures over the past decade.

Conference presentations and recommendations underscored the importance of equity as a central concern for **#HealthElection16** policies and debates. The recommendations (see bottom of this post) also give plenty of pointers for journalists and media outlets for topics for investigation and focus during the election campaign.

Croakey acknowledges and thanks rural health advocate Alison Fairleigh for providing the following clips of some conference presentations. Do take the time to watch these in full, if you haven't already. A short summary is also provided.

Beneath the presentations are some tweets from the participants, and the conference delegates' priority recommendations.

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The changing nature of children's health

Professor Frank Oberklaid, Foundation Director of the Centre for Community Child Health at The Royal Children's Hospital in Melbourne, said funding and service models are lagging 20 to 30 years behind the scientific evidence showing the impact of disadvantage upon children's development and future wellbeing.

Poverty and environments causing chronic stress were THE critical health issue for many children, affecting development and beginning a trajectory affecting health into adult years, he said.

"You can't be exposed to the research on brain development and continue business as usual," he said, warning that current paradigms of policy and services needed to be disrupted.

Chronic stress was having biological effects on young children that interfered with optimal brain development and affected their systems, making their more vulnerable to problems throughout life.

This "biological embedding of environmental events" was compounded by barriers to services. Children affected by chronic stress were in "double jeopardy" because they were most likely to benefit from support and quality early education – but least likely to have access.

Oberklaid said that "most paediatric admissions represent a failure of the healthcare system", and called on the health sector to become advocates for prevention.

He urged hospitals to embrace a new mission positioning themselves as systems of care, rather than remaining focused on beds and treatment of presenting cases.

The earlier an intervention in children's lives, the less it cost and the more likely it was to be effective. However, governments tended to respond later, when interventions cost more and were less likely to be effective.

Governments generally responded too late, providing "political solutions not scientific solutions."

Oberklaid said prevention is hard to sell to governments because it's invisible.

"There are no plaques on buildings there are very few photo opportunities, there are no announcements to make," he said.

"Building capacity in families and building capacity in communities is really the only game in town, and yet it's such a hard sell to policy makers."

The changing nature of children's health - Professor Frank Obe…

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Governments to do things differently

A process of genuine reconciliation is needed to re-set the foundations of what has been "a profoundly damaged and damaging relationship" between Australia's First Nations and those who have come afterwards, Pat Anderson told the conference

Consistent, evidence-based policy processes with Aboriginal input and control were vital, she said.

"What we don't need is unfortunately what we have had for the last ten years. The last ten years have been horrific for us."

Anderson described the damaging impacts of the NT Intervention and its subsequent iterations, as well as the Indigenous Advancement Strategy, which had led to funding cuts for successful community controlled programs.

Government had expended lots of energy but achieved little, she said.

"It's like government is running really, really fast; their arms are pumping, their legs are going – but they're running on the spot, they're just not getting anywhere."

Anderson also described the harmful impact of the profound mistrust shown by governments and policy makers towards Aboriginal peoples, knowledges, and communities.

"It doesn't make any difference how good you are, if you are an Aboriginal organisation working with Aboriginal people, you have to all the time justify your existence and we're getting a bit sick of it," Anderson said.

Discrimination, racism and exclusion from the life of the nation powerfully shape the health and wellbeing of Aboriginal and Torres Strait Islander children from before they are born and throughout their lives, she said.

Pat Anderson also acknowledged the recently retired CEO of the NRHA, Gordon Gregory, as a supporter of Aboriginal organisations over the years. "I can speak for all of us in saying, he will be missed," she said.

A Northern Territory perspective on healthy infants and kids - …

Improving health outcomes for Aboriginal and Torres Strait Islander children

Professor Kerry Arabena, Chair of Indigenous Health at The University of Melbourne, admonished some conference presenters for using deficit language and framing, describing the trauma this inflicts upon Aboriginal and Torres Strait Islander people.

"We are precious and extraordinary and smart, and capable beyond words. I need you to carry that in your heart away from here when you leave here," she said.

Arabena also called for new forms of discourse around family violence and disability, and for an end to the "casual" violence inflicted upon Aboriginal men through stereotyping. As well, she called for discourse that acknowledges sexual diversity.

Arabena urged a greater focus on the preconception period – "the best way to talk about pregnancy with people is when they're not" – and on addressing STIs in young people, and to ensure access to safe termination services.

She urged conference participants to take some responsibility for changing racist, oppressive health systems.

New forms of entrepreneurial systems were needed, she said, to develop business opportunities for those who don't want to work in racist systems.

"We don't want to do things better, we want to do better things," Arabena said.

Arabena also discussed ground-breaking work in the First 1,000 Days (as featured in the next article).

An integrated model of child and family services – Donna Ah Chee

Putting the spotlight on the first 1000 days, to improve children's futures #LongRead

The first 1000 days is the name of a global movement that recognises the importance of the period between conception and a child's 2nd birthday as a unique window of opportunity to shape healthier futures.

The right nutrition and care during this 1,000 day window can have a profound effect on a child's ability to grow, learn, and achieve their potential.

Professor Kerry Arabena, Chair for Indigenous Health and Director of the Onemda VicHealth Koori Health Unit, and colleagues in the Indigenous Health Equity Unit in The University of Melbourne's School for Population and Global Health are driving First 1000 Days work in Victoria and Australia more widely.

A recent symposium at the University of Melbourne examined what is needed to ensure the best start for Aboriginal and Torres Strait Islander children during this period, and heard of several promising initiatives from across the country.

Participants heard the The Abecedarian Approach is grounded in the three interlinked domains of learning games, conversational reading, and enriched care-giving, unified through the overarching concept of language priority.

To reduce the worrying rate of removal of children from families, the symposium heard that the best results come from coordinated interventions that properly engage parents and vulnerable children with interrelated issues — such as maternal mental health, parental incarceration, racism and familial stress — and also engage with the child protection and welfare systems.

The symposium also heard of the importance of better engagement with fathers and their greater involvement in the early stages of parenting.

Many thanks to Professor Kerry Arabena for providing this report of the symposium.

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Kerry Arabena writes:

More than 100 participants from over 30 different institutions were present at the 'First 1000 Days Scientific Symposium' led by the Indigenous Health Equity Unit in The University of Melbourne's School for Population and Global Health.

The Symposium focused attention on the fundamentals of human development at a time in a child's life when changes in service integration and family engagement can deliver on the promise of childhood equity.

It promoted multi-agency strategies that engage families to focus on the early period of child development, the first 1000 days from conception to age 2 years.

It considered how to develop and apply high quality evidence to the issue of childhood vulnerability in Aboriginal and Torres Strait Islander populations that is grounded both in the neuroscience of early brain development and in the complex effects of social and community environments on children's development.

Mr Andrew Jackomos provided an overview of his work in Victoria as the Aboriginal Children's Commissioner. He highlighted a strengths based approach, emphasising the successes of the majority of Indigenous peoples, and the critical role of kin and culture for those that are vulnerable in the population. Amongst the latter, issues surrounding the removal of Indigenous children were key.

Vulnerability amongst children was multifactorial in origin, and predisposed the child to exposure to neglect and abuse in both the family context and in the state care intended to protect them. Despite good government intentions, poor outcomes have continued to escalate, with increased rates of out-of-home care increasingly in non-Indigenous communities.

Research into the factors impacting on reasons for and the impact of out-of-home care has examined causal factors, service provision, the experiences of the child, and monitoring and facilitation of the timing of return to the family.

Major drivers to out-of-home care or poorer outcomes subsequent to care include lack of role models, increased rates of autism amongst children, inter-generational trauma, placement in non-Indigenous contexts and lack of understanding of cultural connections and community input, the influence of substance abuse and incarceration, and, critically, male domestic violence.

Active community involvement and linkages between service systems including justice, health and education were highlighted as key for future progress and enhanced outcomes.

Participants also heard that coordinated interventions that properly engage parents and vulnerable children with interrelated issues — such as maternal mental health, parental incarceration, racism and familial stress — and also engage with the child protection and welfare systems, have the best chance of being effective.

Effective programs in Central Australia

Two regional approaches that promote multi agency strategies that engage families and focus on the early period of child development from conception to age 2 years include preventative programs from the Central Australia Aboriginal Congress geared towards increasing attendance and engagement – the Nurse Family Partnership Program, and the Congress Preschool Readiness Program- and the 'Baby One Program' from Apunipima Cape York Health Council from north Queensland.

Led from community controlled health agencies and supported by universities, these initiatives support service specific enhancements at the local and regional levels to ensure supports are equitably available for vulnerable families.

The Congress Preschool Readiness Program – a 7 week initiative for children 31/2 years of age which utilises the Abecederian Approach-aims to increase school preparedness and participation amongst indigenous children through assisting with preschool choice, enrollment and in the provision of practical support.

The program has demonstrated remarkable gains with rapid improvements in developmental outcomes amongst the majority of the children who participated, with participation in the full 7 weeks yielding developmental advances equivalent to 6 months duration, as measured using Bayley scores.

Critically, however, those children who were the most disadvantaged failed to demonstrate gains, indicating that intervention occurring at this stage of child development may already be too late for these children.

The Nurse Family Partnership Program, by contrast, is a parent focused intervention geared towards improving pregnancy outcomes, child health and development, and enhanced parental self sufficiency, by means of the establishment of a therapeutic relationship emphasising continuity of care between a nurse and the child's mother from 28 weeks gestation to 2 years of age.

These programs emphasise the benefit of pre-distribution-targeting the child at the earliest stages of development- in conjunction with more traditional concepts of redistribution and remediation, to maximize potential.

Learning from Cape York programs

Similarly, the Baby Baskets program from Cape York, was developed to promote better maternal and child health outcomes for women in the Cape York communities in Queensland.

It was developed by the Apunipima Cape York Health Council, and as such reflects self-governance and local ownership. Baskets, with items supporting antenatal and postnatal care for the mother, infant and wider family, promoted engagement with health care workers and information exchange, trends which were borne out in subsequent evaluations.

The success of this program precipitated the genesis of the Baby One Program, which encourages holistic, family based antenatal and postnatal care driven by indigenous health workers and the local community.

It focuses on enhancing engagement between families and health workers and providers, the empowerment and education of health workers, and facilitating information exchange on health education and promotion, during the first 1000 days, and into subsequent pregnancies. This is enabled through home-based visits commencing during pregnancy with continuity of care through engagement with the same health worker throughout.

Health workers also benefit from participation in the program, through ongoing professional development and education on best practice models of care, which permit empowerment and capacity building.

Significantly, the program has identified the need for better engagement with fathers and their greater involvement in the early stages of parenting. This is being addressed through current efforts to source funding to engage male health workers.

Internationally, the First 1000 Days is focused on reducing undernutrition around the globe. Combining evidence based medical care and social support, it includes actions that target:

- adolescents — through healthy behaviour modification, delaying pregnancy and parenting education;

- women of reproductive age — with preconception care, good nutrition, healthy lifestyle education and strategies to reduce gestational diabetes;

- neonates — through promoting breastfeeding, good nutrition, and family support and preservation; and infants and children — with good nutrition, family support and appropriate learning and stimulation.

Early benefits last a lifetime

The Symposium also demonstrated the importance of the First 1000 Days across the lifetime. Taking an ecological approach to early childhood, adolescence and ageing, participants heard from leaders in the field about the ways in which the first 1000 days can catalyse equity across a person's lifetime.

Professor Joseph Sparling from the University of Melbourne discussed the critical role of development and intervention within the first 3 years, in terms of impact on the life course, as highlighted by James Heckman.

He emphasised that early interventions with proven efficacy demonstrate benefits right across the lifespan, including educational outcomes in middle age.

Improved cognitive outcomes in vulnerable children have been demonstrated in those exposed to the Abecedarian Approach across the first four years of life compared with their control peers. The Abecedarian Approach is grounded on the 3 interlinked domains of learning games, conversational reading, and enriched care-giving, unified through the overarching concept of language priority.

After very promising outcomes following interventions using the Abecedarian Approach in Canada and the USA, Sparling is currently conducting the Northern Territory Research Project involving a quasi-experimental intervention arm of exposure to the Abecedarian Approach through parent-child playgroups, compared against a control, with the primary outcome being level of school readiness.

Early findings indicate the importance of dosage, as language development scores were enhanced by increased exposure to reading conversational sessions.

On the importance of adolescence

Dr Peter Azzopardi, an adolescent health researcher at South Australian Health and Medical Research Institute (SAHMRI) and Murdoch Children's Research Institute (MCRI), discussed the unique properties of adolescence from a developmental viewpoint, and its interconnectedness with the first 1000 days.

It provides a window of vulnerability in which limbic areas of the brain regulating emotion and reward develop prior to prefrontal functions of planning and logic. It is the period that coincides with risk raking behavior, the initial stages of family formation and increased roles and responsibilities concerning employment and citizenship. Developments in the first 1000 days and throughout childhood influence, and are consolidated in, adolescence.

The residual negative effects of intra-uterine growth retardation (IUGR) on cognitive outcomes in adolescence can be mitigated by a supportive environment in infancy and childhood. Similarly, whilst opportunities exist for 'catch-up growth' after IUGR in the first 1000 days, rapid growth and weight gain in later childhood and adolescence following initial under-nutrition is associated with increased risks of chronic disease in adulthood. The different disease profiles of Indigenous Australians adds further complexities to the interpretation of current research.

Adolescence may also form the foundations for the prenatal and antenatal health for the subsequent generation. Adolescent pregnancy, more common amongst indigenous Australians compared with the general population, carries increased risk of low birth weight infants, prematurity and increased neonatal mortality. These effects are exacerbated if birth spacing is less than 2 years – a common scenario for adolescent mothers.

Data is, however, largely lacking regarding the impacts particular to Indigenous Australians. Particular areas of focus for healthy adolescent development, using an ecological model to support research, programs and service provision, includes cultural well-being and development, enabling environments which support aspirations, the provision of basic needs, support around issues of justice, key health areas, sexual health and parenting supports.

Early pathways to dementia?

Professor Tony Broe (AO) from the Neurosciences Australia Institute focused on a lifecycle approach to brain growth, ageing, and cognition, in which it is recognized that brain growth and neuroplasticity peak in childhood and adolescence.

The Koori Growing Old Study focuses on urban and regional Koori communities from New South Wales. Elevated rates of dementia were noted amongst Koori participants, compared with national averages, and were consistent across urban and rural sites. Dementia was also noted to have earlier onset generally amongst the Koori participants. Reasons for these results are likely to be complex and multifactorial.

To begin disentangling influences, successful parenting was explored through the proxy measure of the Childhood Trauma Questionnaire. Preliminary findings indicate that childhood trauma and poor parenting are correlated with increased risk of dementia in later life.

Putting the spotlight on the first 1000 days, to improve children's futures #LongRead

Direct impacts upon brain growth such as brain structure and function and indirect mechanisms including co-morbid mental health issues and substance use, are likely to contribute, and argue for interventions directed across the range of risk factors.

All three presenters showed the importance of the First 1000 Days as an enabling environment to support family and community responses to enhance growth and development across a person's lifetime.

We can support the inherent strengths and resilience in communities by bringing together disparate programs — home nursing, child protection and fathering support — with evidence-based very early learning programs. This will allow a coordinated effort in responding to the full impact of social determinants, improve access to comprehensive services and link those in need with local, Indigenous-led services.

This Symposium saw the development of a Scientific Committee to ensure the quality and integrity of work carried out under the First 1000 Days banner in Australia.

Evidence generated through the Scientific Committee will inform the next Symposium aiming to strengthen families through Community Governance and the final Symposium will focus on Policy and Implementation.

Through these Symposiums and the resultant Committees, the Indigenous Health Equity Unit supports the translation of evidence into practice, policy and implementation efforts across Australia. The Delegates Forum will set the agenda for future work.

• *The symposium was chaired by Professor John Mathews, and facilitated by Professor Kerry Arabena.*

Indigenous health

#IndigenousDads: countering racist stereotypes with love & pride

PUBLISHED: **August 07, 2016**

BY: **Aboriginal and Torres Strait Islander people on Twitter**

Aboriginal and Torres Strait Islander men and their families have been sharing moving photos and stories of fathers and fatherhood to counter the racist stereotyping of a **Bill Leak cartoon** published last week in The Australian.

The #IndigenousDads hashtag has trended nationally with heartfelt tributes to love, family and culture.

Below are just some of the many photos that have been shared, and some responses. You can see more tweets in these compilations published by other media:

Mashable: #IndigenousDads trends in Australia in powerful response to 'racist' cartoon

Junkee: The #IndigenousDads hashtag is the perfect antidote to Bill Leak

**ABC: #IndigenousDads counter Bill Leak cartoon with stories of fatherhood**

Pedestrian TV: #IndigenousDads: Australia counters Bill Leak in the best way possible

Guardian Australia: #IndigenousDads and their children take to Twitter over Bill Leak cartoon

You can also read @IndigenousX founder **Luke Pearson's response** to the cartoon, and **this** article by University of Queensland lecturer **Dr Chelsea Bond**.

Aaron Charles Ellis @bigibila · 22h
I'm proud to be his father and proud to be Aboriginal. Our culture is our strength. #IndigenousDads.
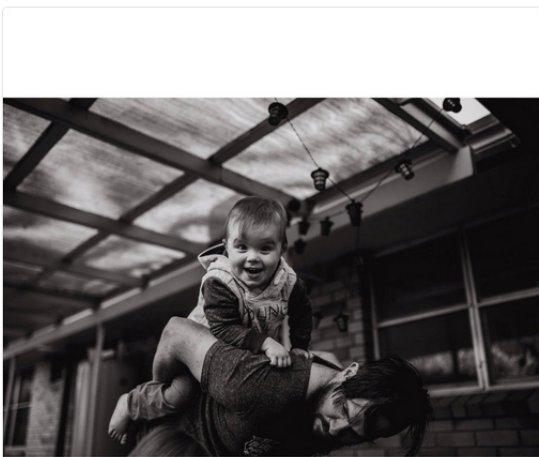
Alec Doomadgee @alecdoomadgee · 20h
"I was going to quit, but then I remembered who was watching"

#WarriorUP!!
#indigenousdads
@ZachsCeremony

#IndigenousDads: countering racist stereotypes with love & pride

Ali Drummond @dauareb · 18h
Uncles are also important in my family. Here with my brother and niece. #indigenousdads

Azza Nagas @azzanagas7 · 5h
Was proud to hear #Indigenousdads trended last night. here's my contribution of my beautiful jarjums & I #love

Antoinette Braybrook @BraybrookA · 1h
My brothers love & would do anything for their 6 daughters #IndigenousDads. My brothers respect women @FVPLSVictoria

Chris Lee @Scutjingah · 3h
#IndigenousDads My world. My girls

Bronwyn Fredericks @BronFredericks · 2h
My partner Rodney is a deadly Indigenous dad & grandfather! #IndigenousDads rock! mobile.abc.net.au/news/2016-08-0…
👤 Aboriginal Health, Melissa Sweet, Marlene Longbottom and 7 others

Ryan Griffen @RyanJGriffen · 20h
No only do I know my sons name but I named a superhero after him. #IndigenousDads #Cleverman

809   1.6K

#CulturalSolutions forum calls for strengths-based, localised approaches to preventing suicide

PUBLISHED: **July 07, 2014**

BY: **Summer May Finlay**

The Healing Foundation convened a public forum with live streaming in Canberra, called *Cultural Solutions: Understanding Suicide: trauma capability and responses in Indigenous communities*.

Summer May Finlay, a Yorta Yorta woman and public health researcher, covered the event for the **Croakey Conference Reporting Service**.

. . . .

Summer May Finlay writes:

Right from the start you knew that this forum was going to be different.

The difference was that the conversation was not centred on the devastating statistics of suicide from among the Aboriginal and Torres Strait Islander communities, but on solutions.

The panellists (pictured) included Professor Michael Chandler as **keynote speaker**, Pat Anderson AO, Professor Ngiare Brown, Jeremy Donovan and MC Greg Turnbull.

The key take home message from all the speakers was that there is not a "one size fits all solution", but rather solutions that would address individual community needs.

Speakers also called for solutions based on strengths, rather than deficits.

These principles are the reasons why Richard Weston, the CEO of the Healing Foundation, felt it was important to have Professor Michael Chandler at the forum. He said:

> *Chandler's strength-based approach aligns with the work of the Healing Foundation, and that's why we wanted him here, to start sharing this different ways of looking at these problems.*
>
> *Once we break it down it down, it's still heart breaking to have suicides in community but it's not a national problem, it's in a few places and there are causes, we just need to tackle those causes to better target our strategies."*

croakey

Emeritus Professor Michael Chandler is a Distinguished Scholar in Residence at the Peter Wall Institute for Advanced Studies. His **research** has highlighted the value of taking strengths-based approaches to suicide prevention in communities, including the importance of cultural continuity.

Not only was the focus of the conversation different at this forum – the way it was being held was different.

The forum had a live audience but was also streamed live across the country. In addition to the 70-plus audience, over 120 groups viewed the forum remotely.

And it was not only the panellists who did the talking. Questions came in via the hashtag **#CulturalSolutions**, a pre-recorded video, and voice calls over the Internet as well as from the people in the audience.
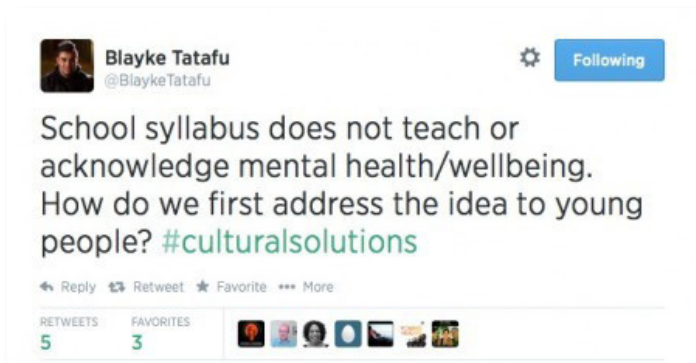
Jeremy Donavan, Healing Champion at the Healing Foundation and Executive Director at Generation One – Indigenous Employment Initiative, answered with:

> " *Children don't fit in boxes; we are all rounded in different ways and education needs to reflect this. We need to empower children to have the conversations which haven't been had in the past."*

The Healing Foundation believes in working directly with communities, that communities have the answers, and we just need to be having the conversations – which is why they wanted as many people to participate as possible.

This is what motivated them to open up the forum to people through the Internet.

Pat Anderson AO, an Alyawarre woman, is recognised both in Australia and internationally as an advocate for disadvantaged peoples, specifically for Australia's First Nation's people.

She believes that suicide is a difficult and "vexed" conversation, but one we need to have.

She believes there is "no quick fix, no one solution", and that every community needs to find its own solutions.

Jeremy Donovan echoed these sentiments: "We have to have these difficult, sensitive, painful, heartbreaking conversations".

Mr Weston said:

" *We have a lot of knowledge in our communities so we've got the foundations to deal with the issue of suicide and other harms that are going on in our communities but we have to improve our language around it, we have to describe it.*

Everyone needs to buy into it and we have to invest, we have to engage our communities in that journey with us not sit here in Canberra and design these programs."

Professor Chandler's work focuses on the communities with few or no suicides to understand the protective factors, to learn how to heal. His work looks at the markers for "cultural continuity" and "self-continuity".

Professor Chandler believes that culture is the foundation for healing, and that "cultural wounds require cultural medicines".

Professor Ngaire Brown, a proud Yuin nation woman, also believes culture is the solution. Professor Brown talks about Cultural Determinants rather than Social Determinants of Health.

She believes that the Social Determinants take a deficit approach whereas a Cultural Determinants approach is focused on strengths (listen to **her interview** with the National Indigenous Radio Service).

Talking about suicide is hard, not having the conversation though isn't going to make it go away.

The Healing Foundation made a brave decision to open up the forum to as many people as possible by streaming it live and utilising Twitter. And it paid off.

Making technology work for us is important, it allows us to bring everyone together. Without the innovative use of technology, the Healing Foundation's message wouldn't have had the same national impact.

• *Summer May Finlay is a Yorta Yorta woman who grew up on Lake Macquarie. She has a Bachelor of Social Science and a Masters of Public Health, and has worked in Aboriginal affairs, in a range of capacities, for 10 years. She tweets as @OnTopicAus and has a blog, On Topic which you can read at http://summermayfinlay. blogspot.com.au. You can read more about her at The Guardian.*

For help or more information

For people who may be experiencing sadness or trauma, please visit these links to services and support

#CulturalSolutions forum calls for strengths-based, localised approaches to preventing suicide

- If you are depressed or contemplating suicide, help is available at Lifeline on 131 114 or **online**. Alternatively you can call the **Suicide Call Back Service** on 1300 659 467.

- For young people 5-25 years, call **kids help line** 1800 55 1800

- For resources on social and emotional wellbeing and mental health services in Aboriginal Australia, see **here**.

"Why aren't I in prison?" … Some questions about white privilege #JustJustice

Public health concerns like white privilege and racism were on the agenda at the **Leaders in Indigenous Medical Education Network** conference in Townsville (see more details in this **previous post**).

These are also critical issues to address in efforts to reduce the over-incarceration of Aboriginal and Torres Strait Islander people.

In his contribution to the **#JustJustice project**, GP Dr Tim Senior investigates white privilege and how it contributes to unfair systems.

. . . .

White privilege: a barrier to #JustJustice

Dr Tim Senior writes:

Why aren't I in prison? To be sure, I haven't committed a crime (unless you count stealing a comb from a newsagents when I was two, which my mum made me take back).

I have been fined for speeding once – and driving offences are **just the sort of thing that can end up with people being put in jail**. Perhaps I should think of that as a narrow escape?

The fact that I don't consider this a narrow escape says something about the answer as to why I am not in jail.

Sit down, though. The answer to my question might make you uncomfortable.

The principle reason that I am not in jail, is that I am white. There. I said it.

Why have I come to this conclusion?

Look at the imprisonment rates for Indigenous and non-Indigenous Australians.

Figure 3.20: Imprisonment rates in adult prisons, by Indigenous status, 2000 to 2014

Any explanation is going to have to account for that low, and pretty much flat, rate of non-Indigenous incarceration, and that high and climbing higher rate of Indigenous incarceration.
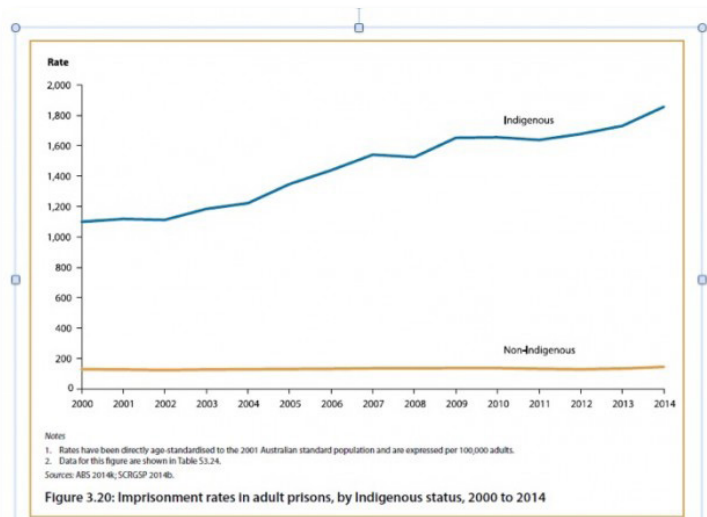
In the dark recesses of racist Facebook, you might see suggestions that Aboriginal people are just inherently more criminal. This is not only wrong, and explains nothing, it is also a deliberate way of saying "…and I don't want to know."

The reason for the differences in incarceration rates could be that Aboriginal and Torres Strait Islander people are **committing more (or more serious) crimes**, that the police are **more likely to charge Aboriginal and Torres Strait Islander** people for **relatively minor crimes**, or that courts are **more likely to sentence Aboriginal and Torres Strait Islander people to imprisonment**.

There's truth in each of these statistics, but let's ask again: "Why?"

There's a theme that unites all of these reasons, in the society that produces these effects. Naming it provokes deep reactions, but once it is named and explained, it's possible to see its work everywhere.

What is going on here is **white privilege**.

They don't teach this in medical school – **I'll leave you to consider why**! So these ideas are relatively new to me and, as I learn about the unearned privileges I receive, I may be prone to misunderstandings and understatement. That's because, as much as I try, it's hard for me to see the world without my privilege.

Let's think back to that time I was caught speeding. Though I was upset at the time, I never **feared for my safety** from the police officer, and assumed I'd be treated fairly. I never thought I'd be **imprisoned for a minor traffic offence**. I wasn't asked to open the boot, or have the car searched – there was no reason to – but sometimes there is no reason to, and it still happens.

What if the police officer had looked in my car? What would she have found?

Well, echoing a **well known description of white privilege** by Peggy McIntosh (who lists what's in the "invisible knapsack" of white privilege), the police officer would have found a general assumption that the police can be trusted. Also present would be a usually correct assumption that the police officer would be of a similar background to me – why else do the police need specific Aboriginal liaison officers?

Wrapped up in a parcel on the back seat was my belief that if I was unhappy about how I was treated, I'd be able to see a superior police officer, whose background was also similar to mine. Tucked away in a plastic bag was my knowledge that I'd be able to get a lawyer and be seen by a judge who would also be a bit like me.

Aside from this, I'd know that hidden away with the spare tyre, there weren't media stories about people like me that drew on my appearance or race to make me seem scarier or more violent than I am.

And tucked in the glovebox is my CV, which, because it has an English-sounding name at the head, **is more likely to land me a job interview**.

croakey

I can go on. The car is full-to-overflowing of my white privilege. Behind the seat is knowing that politicians making the laws mostly have my racial background. I can glance in my rear-view mirror to see that my cultural background is shared by most journalists choosing what is news and how those news stories will be framed. I can also recognise myself in those teachers at school and at uni who were encouraging me and helping to set my course.

It's not just this one interaction with the police where my white privilege might be exposed, either. If the police officer wanted to search my home – more likely to be **rented from someone else if I were Aboriginal** – they'd find white people like me **in my television dramas**, more comfortable about **sitting next to me, or allowing me to shop without suspicion**.

Everywhere I look, in fact, is the message "Yes, you fit in here. You belong." It's nice and comforting. For me, and for other white people like me, life is like **playing the computer game on the easiest setting**.

To say this in public though, can lead to abuse and anger – so called **white fragility**, a state in which even a minimum amount of racial stress becomes intolerable, triggering defensive reactions among white people, such as anger, fear, and guilt.

I'm not saying that white people have it easy, or have no problems, or never go to jail. I'm not saying all white people are racist (though some honesty like this from **Daniel Reeders** would go a very long way to improving the situation).

We are (thankfully) not all Bolt wannabees. It's much more subtle, complex and interesting than that. The structures that we have built society on, and colonised Australia with, have resulted in a whole heap of unspoken advantages to people like me, at the expense of people like my Aboriginal patients.

It's why they relax in the community controlled service I work in – because it says, unlike so much of mainstream Australia's institutions and systems, "Yes, you fit in here. You belong."

There is a common enough understanding that racism is A Bad Thing, so even those who boo Adam Goodes don't like being called racist. We now need to see and acknowledge the racist structures that we all live in, that exist in out health systems, in our legal systems and across our whole society.

Those imprisonment rates, those health statistics we see are symptoms of those societal structures. That is why we see similar figures right across the world.

Those statistics are the result of white peoples' privilege and how white systems disadvantage and exclude others. It's repeated for **Maori people in New Zealand**, for the **Aboriginal people of Canada**, and for **black people in the US**, which should tell us we're not dealing with an Aboriginal and Torres Strait Islander problem here.

We are seeing the application of a dominant culture to exclude others.

We have to acknowledge this – which means those of us who benefit from white privilege need to do the most to change unfair systems – and perhaps risk losing some of our advantages in the process.

Those advantages can be hard to see. To help bring them to the surface, watch this video that tests your awareness.

"Why aren't I in prison?" … Some questions about white privilege #JustJustice

Once you start seeing white privilege, like the surprise in this video, you notice it every time you look.

• *Dr Tim Senior is a GP who works in Aboriginal health, a contributing columnist to Croakey, and author of #WonkyHealth – the e-book. Follow him on Twitter: @timsenior*

#SDOH

Global health

croakey

Planetary Health – the new public health paradigm

PUBLISHED: **February 16, 2016**

BY: **Peter Tait**

Planetary Health is a new concept which brings together a number of different areas of health and ecology to express the inter-dependency of all human and natural systems and the importance of ecological systems for human health and well-being. It is concept that is particularly relevant in understanding and responding to the health impacts of environmental degradation and climate change.

For those who are not yet familiar with this term, GP **Peter Tait** has provided the following brief explanation of the growing Planetary Health movement and outlined its potential to influence the development and implementation of health policies and programs. He also suggests the possibility of establishing an Australian Planetary Health network.

Peter Tait writes:

Emerging on to the public health stage in 2014, the concept Planetary Health provides an overarching meta-disciplinary model that brings together the disciplines of **One Health** (itself a transdisciplinary entity**[1]**) with **Ecohealth**, also a composite of ecological public health and human ecology, with an element of political economy and political ecology. This synthesis gives voice to the vital idea that human existence, civilisation and wellbeing (prosperity, health) is grounded in the environment of the planet on which we live.

What this means is that the relationships between humans, biosphere energy and nutrient cycles, the plants, animals, fungi and microbes with whom we share this planet, is made overt. Further, planetary health brings our relationship with future generations and their wellbeing into consideration.

The focus to those relationships is putting a **biosensitivity** and ecocentric frame into public health, which has two important effects on public health and health care systems. My purpose here is to tease these out for the non-public health community.

Opening a discourse

Firstly it opens a new discourse about the place of people in nature that counters the current dominant western post-enlightenment economic paradigm. Second it invites health practitioners to alter the way they think about public health and health care practice.

Environmental health was the origin of public health as a discipline and a movement. Therefore in this century it behoves public health to promote this determinant of existence, civilisation and wellbeing along with the more recently recognised social determinants of health. In fact planetary health recognises that environmental and social determinants of health are linked by the realisation that it is human politics that is the instrument whereby existence, civilisation and health are created and maintained (or not).

A systems-based, ecological approach

What this means for medicine, health care and public health is that practitioners need to adopt and promote a systems based, ecological approach to energy and materials use, to the application of technology, and to clinical practice. Antibiotic use and infectious disease treatment provides a topical example, as does the widespread use and dispersal through the ecosystem of biologically active chemicals. But deeper conversations about public health planning and responses, quality versus quantity of life, reframing primary prevention strategies and even the function and structure of health care systems emerge.

Within the health sector in Australia, a Planetary Health network is possible. Discussion about this possibility is currently underway. Such a network has potential to provide an Australian locus for this approach and link into a growing global Planetary Health movement.

Planetary Health Alliance

Globally Harvard University, the Wildlife Conservation Society and the Rockefeller Foundation, with other partners, announced in early 2016 the launch of the **Planetary Health Alliance**, an effort to improve understanding of the complex relationships between environmental change and human health around the globe. This builds on the Lancet 2014 *Planetary Health Manifesto* followed by the **Rockefeller – Lancet Commission** report, Safeguarding human health in the Anthropocene epoch. Subsequently the Canadian Public Health Association released its report, *Addressing the Ecological Determinants of Health: Global Change and Public Health*, which includes an agenda for action for responding to, safeguarding and promoting planetary health.

The Rockefeller Foundation–Lancet Commission defined planetary health as:

"the achievement of the highest attainable standard of health, wellbeing, and equity worldwide through judicious attention to the human systems—political, economic, and social—that shape the future of humanity and the Earth's natural systems that define the safe environmental limits within which humanity can flourish. Put simply, planetary health is the health of human civilisation and the state of the natural systems on which it depends"

In other words, Planetary Health is a public health prevention and health promotion activity, central to public health action, whose time has come. It links with promoting a wider biosensitive approach to human behaviour. It offers opportunity for human ecology to re-join public health in a movement to achieve human wellbeing.

Peter Tait has been a General Practitioner for 35 years, 30 in Aboriginal health in Central Australia. He was the 2007 RACGP GP of the Year. He achieved a Masters of Climate Change at ANU in 2010. He is an Adjunct Senior Lecturer at ANU Medical School.

Peter believes a person's health is grounded in a healthy society, and a healthy society on a healthy ecosystem. He is on the Board of the Public Health Association Australia and active as convener of the PHAA Ecology and Environment Special Interest Group, and in the Climate and Health Alliance, Frank Fenner Foundation, the Canberra Alliance for participatory Democracy, and other environment and peace groups.

[1] *One Health: human health (public health and infectious diseases), veterinary science, food and agriculture, and environmental health.*

Trading away health? The story of a health impact assessment that made a splash

A **health impact assessment** of the proposed Trans-Pacific Partnership Agreement recently made headlines and won some political attention for the wide-ranging public health concerns raised. What were the factors that contributed to this splash?

Fiona Haigh and Katie Hirono write:

The **Trans-Pacific Partnership Agreement** (TPP) is a large regional trade agreement currently in the final stages of negotiation and involves countries around the Pacific Rim, including Australia.

Traditionally, a free trade agreement (FTA) is an agreement between two or more countries, which aims to remove barriers to trade such as tariffs or import quotas to member countries. Increasingly FTAs have shifted to encompass not just the regulations related to the exchange of goods and services but also to rules regarding intellectual property, investment and many other issues.

As these rules have expanded, so too has their potential to impact on public health. For example, changes to intellectual property rules can lead to **increasing costs of medicines** and an investor state dispute mechanism can threaten public health measures such as **tobacco plain packaging**.

The TPP is being negotiated under conditions of confidentiality, and consequently negotiating documents are not made public and limited information is available. This makes it difficult for those interested in public health to engage in the process and provide expert input into decision-making process.

There are growing **concerns** that the TPP may have serious negative consequences for public health.

At the end of 2013 a small group of public health academics decided to carry out a Health Impact Assessment (HIA) of the TPP. HIA involves predicting how a proposal (such as the TPP) may impact on public health and developing evidence-informed recommendations to inform decision-making and implementation.

HIA has been **identified** as one of a limited number of methods that are available to address the social and environmental determinants of health prior to implementation of proposed policies, plans or projects to maximise future health benefits and to minimise risks to health.

The process

The HIA team at **CHETRE** worked with a group of academics and Australian non-governmental organisations to carry out the HIA. We focused on four areas of potential impact:

• The cost of medicines;

Trading away health? The story of a health impact assessment that made a splash

- Tobacco control policies;

- Alcohol control policies; and

- Food labelling.

For the HIA we applied a range of methods including:

- reviewing literature for evidence about the potential impacts of trade agreements on health;

- accessing national data;

- consulting with experts; and

- carrying out an assessment workshop with 35 participants.

There were some technical challenges with trying to do an HIA on something that is being kept secret. We had to base our assessment on leaked documents and consultation with knowledgeable academics and policy experts.

We also faced the challenge of trying to predict likely future public health policies that could be affected by the trade agreement (since some parts of the TPP are more likely to affect future policies than policies that are already in place). We approached this by working with policy experts to identify likely future public health policies in our scoped areas of focus that could be impacted by the TPP.

Since the purpose of the HIA was to inform advocacy around the TPP negotiations, we decided that we needed to engage with these groups throughout the process. We did this by establishing an Advocacy Advisory Group, which included 11 advocacy groups.

We also set up a technical advisory group made up of leading experts in various fields related to the potential health impacts relating to the TPP. Both of these groups helped us decide what areas to focus on, directed us to relevant evidence and provided their expert input. A crucial part of this was the assessment workshop where we all met to discuss and agree on the evidence-informed impact pathways for each scoped area and then use this analysis to identify some initial recommendations.

We found that many of the provisions that have been proposed for the TPP are likely to result in negative impacts to public health. In particular:

Medicine

The TPP risks increasing the cost of the Pharmaceutical Benefits Scheme (PBS), which is likely to flow on to the Australian public in terms of increased co-payments (out-of-pocket expenses) for medicines. This may result in medical non-adherence for prescription use and prioritising health costs over other necessities (food, housing, etc.). Vulnerable groups include those from low socioeconomic backgrounds, people with chronic conditions, younger populations, and Aboriginal and Torres Strait Islander peoples. Potential risks to health outcomes include declining health status in the community, increased hospitalisations and increased mortality.

Tobacco

The TPP provisions pose risks to the ability of Government to regulate and restrict tobacco advertising. This could potentially lead to increased tobacco use and smoking prevalence, resulting in increases in tobacco related health harms across the community but particularly for existing vulnerable groups, such as youth and people with low socioeconomic status.

Alcohol

Some provisions proposed for the TPP have the potential to limit regulation of alcohol availability and alcohol marketing, and restrict alcohol control measures such as pregnancy warning labels. This risks increasing alcohol consumption rates and abuse, especially amongst young members of the community. This may lead to increased alcohol related disorders, worsening mental health and social disruption in the community.

Food

There is the potential for TPP provisions to restrict the ability of Government to implement new food labelling policies, limiting reductions in consumption of unhealthy foods. This is associated with rates of overweight/obesity and related health outcomes.

(**TPP HIA report** pg iv)

Recommendations and outcomes

Based on the results of the assessment, we developed 19 recommendations to mitigate the potential harms. The recommendations are made to the Department of Foreign Affairs and Trade (DFAT) and Government regarding TPP provisions; the Australian Government regarding the TPP negotiating process; and Broader policy recommendations to Government in the areas of medicines, tobacco, alcohol, and food.

One of our main recommendations is that when the text does become available, a comprehensive impact assessment should be carried out. (TPP HIA report pg 22)

The report has attracted a lot of attention and in general has been a different experience from the typical HIAs with which we have been involved. We have been reflecting on the process, and would like to share a few thoughts.

This HIA was different from the outset in that we weren't commissioned to do the HIA – a small group of us thought it would be a worthwhile thing to do and we managed with some support from CHETRE and the Public Health Association of Australia to keep it going.

Being uncommissioned meant that we could be flexible in our approach and adapt the process to fit the context. The support from CHETRE enabled us to bring in a researcher to do a lot of the analysis and writing and we were supported by a group of experts and advocacy groups who contributed their expertise and advice.

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We also 'walked the talk' of taking a participatory approach, which meant sharing power with the technical advisory group and the advocacy groups that we worked with throughout the process. We feel that this has worked really well – it meant that we focused on issues they identified as important and we have produced a report that they have been able to immediately use for their advocacy.

Without them we're pretty sure this report would not be having the impact it has had so far. The report is being talked about on the **front pages** of major newspapers, there have been multiple **radio** interviews, a social media **campaign** led by one of our advocacy partners CHOICE, and public conversation on Twitter and Facebook.

Perhaps most satisfying of all is that the report appears to be influencing the political sphere. Media reports of the HIA findings have been dismissed by the Minister for Trade and Investment as a **'beat up'** and the Greens spokesperson for Trade, Senator Peter Whish-Wilson, **defended** those who raise concerns about the TPP; the Labour shadow minister for health also called for **greater transparency** in the negotiations; and the report is being talked about in **Parliament**.

The value thus far of having done this HIA is that we have been able to provide evidence-based research that is useful to our advocacy partners to create a collective voice around the potential impacts of the TPP. One of our colleagues said that in the four years she's been working to publish on this type of work, she's never gotten close to the type of response this HIA has generated. We've been fortunate to have provided important evidence near the tipping point of a relevant public issue.

Our hope is that the HIA proves its worth and that some of the harms we've predicted from the TPP are avoided as a result of our work and the way it has stimulated public discussion about these issues at a critical stage in the TPP negotiations.

Memo to G20 leaders: the three best buys for health equity (and it takes only five minutes!)

PUBLISHED: **November 13, 2014**

BY: **Fran Baum**

The **Brisbane Global Cafe**, which is billed as a "pre-G20 thought-leadership forum", involved "75 of the world's sharpest, provocative and most innovative minds".

The five themes for its two days of discussions were: Improving Human Life; Powering Future Economies; The Digital Age – Entrepreneurship & Innovation; Tourism's New Frontiers; and Cities of the Future.
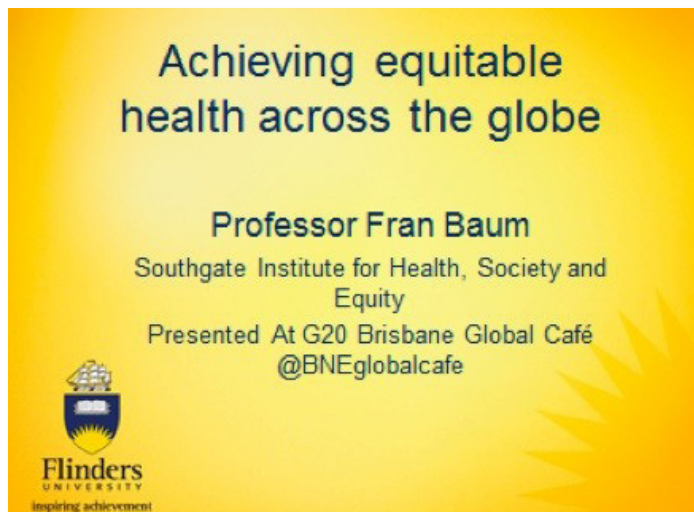
Public health expert Professor Fran Baum shares below her presentation to the forum.

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Fran Baum writes:

I was asked to speak at the pre-G20 Brisbane Global Café on the theme of global health equity and given 5 minutes to do so!

I compiled a set of slides to help me do this. They may be useful to Croakey readers.

The first task was to remind people that the basic causes of unfair patterns of health, unfair access to health care and the conditions that make for health is the unfair distribution of power money and resources.

This situation leads to gross health inequities around the world whereby in countries like Australia and Japan people live to over 80 whereas in many African countries people barely make 50. There is no biological reason for this.
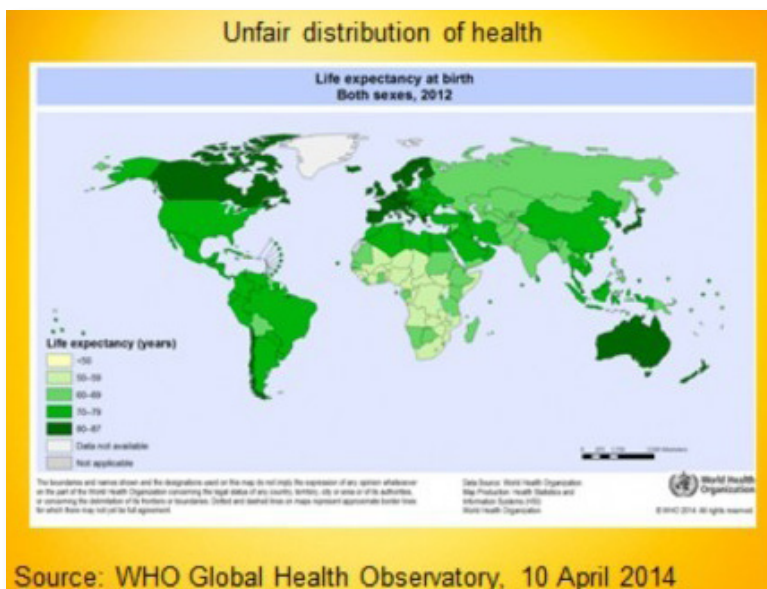
This unfair situation is reflected in the distribution of health services. The infrastructure we have in Australia is so much better than the infrastructure in poor countries like Liberia the epicentre of the Ebola epidemic.

Surely if Liberia had had the infrastructure and ratio of doctors to population that we have then the epidemic would have been curbed earlier.

Memo to G20 leaders: the three best buys for health equity (and it takes only five minutes!)

Yet global health equity will not be solved by health services alone. It is crucial to bring attention to the living conditions that made people unhealthy in the first place.

It is senseless to treat illness and then send people back to the conditions that made them ill in the first place with improving those conditions.

A conservative estimates suggests that 25% of contribution to population health comes from health services. 50% comes from social and economic development and 10% from the physical environment.

This means attention to the social and economic determinants is vital.
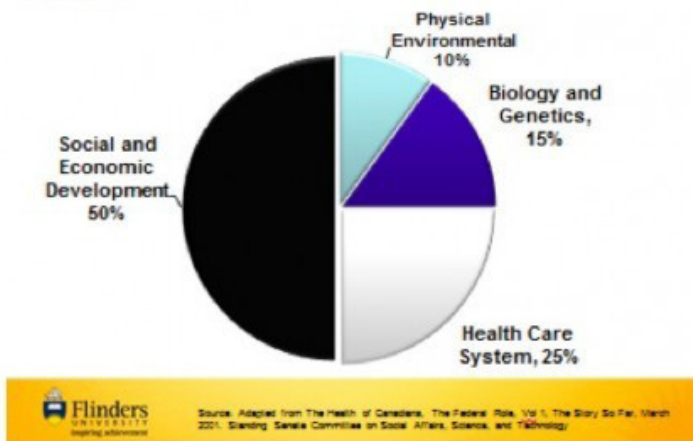
Yet policy responses around the world typically only focus on the tip of the iceberg (Baum, 2009) and are directed at dealing with diseases and behaviours.

Meanwhile, the main drivers of health inequities lie below the iceberg and receive very little policy attention and resources compared to those at the tip.
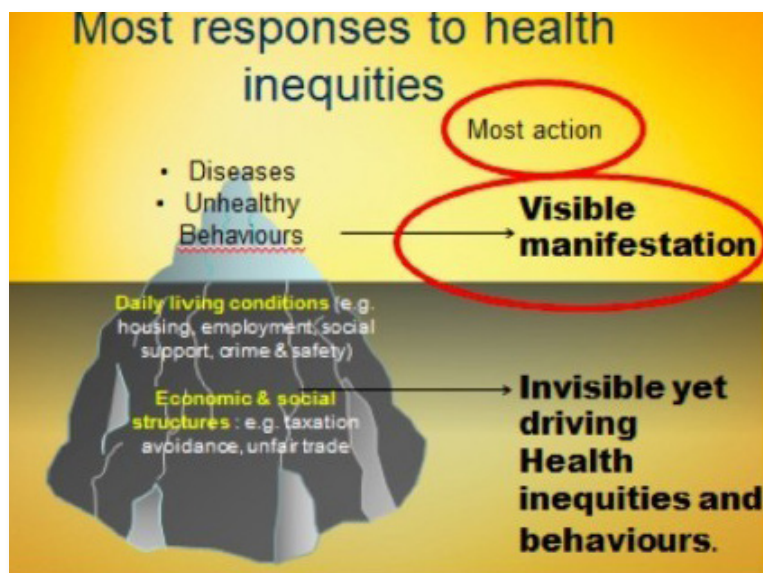

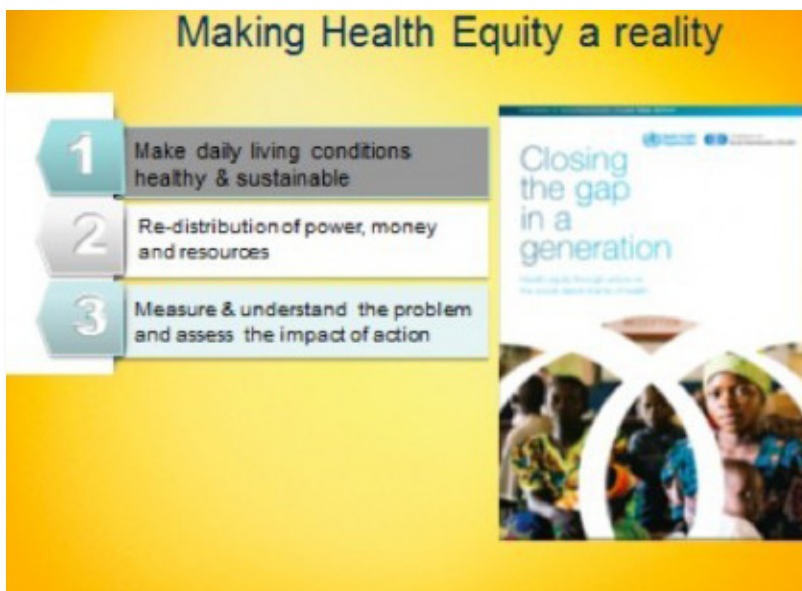One of the most important issues below the iceberg is the unequal distribution of wealth.

More epidemiological evidence (e.g. Wilkinson and Pickett, 2010) points to the ways in which more equal societies do better – they are healthier and score better on a range of measures of well-being.

This means the massive inequities shown in the next slide are very bad for health inequities. As economic inequities are growing, all evidence suggests this will increase health inequities in the future.

Memo to G20 leaders: the three best buys for health equity (and it takes only five minutes!)
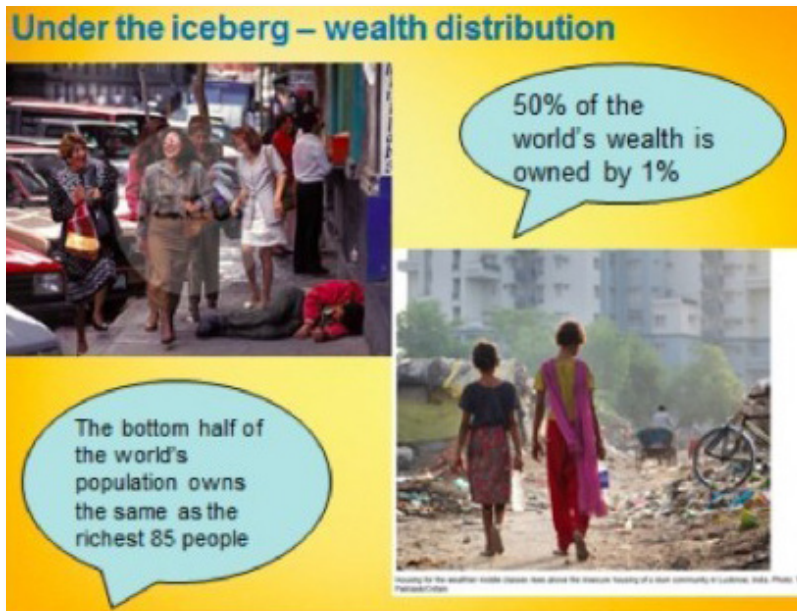
The Commission on the Social Determinants of Health spend three years reviewing the evidence on the social determinants of health inequities and made three headline recommendations that are important for the G20 to consider if they are interested in reducing health inequities.

I boiled down my message for the G20 to three points that are on the slide above.

Memo to G20 leaders: the three best buys for health equity (and it takes only five minutes!)

The G20 could start discussion with the question: how can we provide the conditions to make the next generation of children hopeful, happy and healthy?

Then they could ask how can we change our health systems to ensure that they focus on prevention of disease and massively increase investment in prevention and health promotion?

The revenue for this can be raised by fair taxation and closing down tax havens and ensuring fair terms of trade.

This means ensuring that trade treaties are not only concerned with maximising profits but also with protecting and promoting population health and spreading the benefits of economic development.

References

Fran Baum (2009) Editorial: More than the tip of the iceberg: health policies & research that go below the surface. Journal of Epidemiology & Community Health, 63:957. doi:10.1136/jech.2009.091595

Wilkinson, R. and K. Pickett (2009). The spirit level: Why more equal societies almost always do better. London, Penguin Books.

Some big challenges for health promotion (including the "converging crises" of environmental degradation and social injustice)

Introduced by Melissa Sweet:

The most important task facing the health promotion sector is to help humanity change how we live in order to address "the converging crises of environmental degradation, climate change, resource depletion and social injustice".

This was one of several challenges that UK expert **Professor Mark Dooris** issued to the **Australian Health Promotion Association** (AHPA) conference in Sydney.

Professor Dooris, Reader in Health and Sustainable Development and Director of the Healthy Settings Unit at the University of Central Lancashire, dared the health promotion sector to "envision a different future and to change the way we conceptualise, organise and live our individual, community and working lives".

He urged conference delegates to develop "an ecological perspective" and identify "what makes places liveable, vibrant and enriching" so this can be applied "to the settings of everyday life".

Professor Dooris said:

" *In looking to such a future, it will be important to focus not only on the negatives – the very real risks and 'doom and gloom'; but also on the positives – re-engaging with the environment and the wonder of the world around us; and recognizing that within upheaval lie the seeds of hope and empowerment, and the potential for us to engage and embrace the emergence of new possibilities for enhancing the wellbeing of place, people and planet.* "

He suggested that the health promotion sector needs "to step outside of our comfort zone and engage with and learn from the movements for social justice, sustainable futures and community resilience that have truly become 'viral', such as Transition Towns and Occupy".

He said: "These have clearly captured people's imagination and tapped into the zeitgeist or spirit of the age – and are where some of the most exciting change is happening. There's huge potential for us to build partnerships to tackle some of our most taxing issues."

Professor Dooris also urged conference delegates to deepen their socio-political analysis, and to work with stakeholders and communities to enable them to better understand the wider determinants of health, sustainability and injustice.

The sector should build on strengths and successes – "this means looking for assets and capacities within communities and organisations, rather than focusing only on needs and deficits".

And he stressed the importance of engaging in advocacy aimed at harmonising environmental, social and economic demands, and at pressing governments, multi-nationals and global organizations "to act for health, sustainability and social justice".

Professor Dooris, who is also Visiting Professor in Wellbeing at London South Bank University, was presenting by video and his talk was also delivered at a health promotion conference in Norway today.

A lightly edited version of his presentation follows below.

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Healthy, sustainable and connected settings for the 21st Century

Mark Dooris writes:

Given the focus of my talk, it's probably no bad thing that I'm connecting with you virtually instead of flying across the globe.

When looking at the logistics of me speaking at your conference, we quickly realised that a live link would require me to say something coherent in the middle of the night, so we decided to be pragmatic and opt for a pre-recorded presentation.

I want to start by setting the scene, looking at people and planet in relation to health, sustainability and social justice. I'll then move on to look at place in terms of healthy settings, reflecting on the journey we've taken in health promotion, focusing in on theory and practice and the lessons we've learned over more than a quarter of a century.

I'll then look forward – highlighting what I see as the implications, challenges and principles for practice involved in adopting an holistic and integrated approach to creating healthy, sustainable and connected settings.

It won't be news to most of you that, globally, there are huge inequalities in health between different countries. We also experience stark health inequalities within societies, which are the result of social injustice.

Increasingly used in tandem with the term resilience, sustainability is commonly understood to be about our capacity to maintain or improve quality of life and to endure into the future.

Crucial to this is a commitment to social and environmental justice both within our own generation and between our own and future generations – and to harmonizing environmental, social and economic demands… our economic and social development ultimately takes place within the carrying capacity of our planet and its supporting ecosystems.

Some big challenges for health promotion (including the "converging crises" of environmental degradation and social injustice)

Respect the planet

This echoes what the Ottawa Charter's called reciprocal maintenance, reminding us that if our planet is to support human life and wellbeing, then we need to treat it with respect. Crucial to this is a commitment to social and environmental justice both within our own generation and between our own and future generations – and to harmonizing environmental, social and economic demands

Climate change is perhaps the most high profile sustainability issue. Whilst the science of global warming is complex and contested, there is a huge body of evidence suggesting that climate change is happening.

Furthermore, an analysis of peer-reviewed papers by John Cook from the University of Queensland showed that of the 4,000-plus articles that took a position on the causes, 97% agreed that there is an important anthropogenic component through human activity. Another recent paper by Otto and colleagues concludes that whilst the short-term temperature rise may be slower than previously expected, the long-term scenario is as worrying as ever.

We're all familiar with images showing a rise in sea levels and the melting of polar caps, but it's perhaps less widely known that climate change is now commonly understood to be the biggest threat to human health. We also know that it will be the poor, the vulnerable and the marginalized who will be worst hit by the negative impacts.

In scoping the context of people and planet, there are harrowing things to consider. However, the connections between sustainability and health are not only negative – and it's important to appreciate the positive impacts of the environment.

Starting with the wellbeing of the planet, we know that green space and natural environments can play an important role in storing carbon and reducing CO_2 emissions, in controlling flooding and in sustaining biodiversity.

However, there is also a significant and strengthening body of evidence describing how nature and green space are beneficial to human health. Studies have shown that access to nature and green space is associated with enhanced mental wellbeing, reduced violence and aggression, and increased levels of physical activity; that 'green exercise' – exercise taken outdoors – is more beneficial than gym-based physical activity; and that patients in hospital recover more quickly if they have views of the natural environment from their window.

Again, we also know that access to green space mirrors other indicators of deprivation and is strongly related to health inequalities.

Richard Louv, in his book, '**Last Child in the Woods**', speaks of 'nature deficit disorder' and the particular importance of reconnecting young people with nature.

Some big challenges for health promotion (including the "converging crises" of environmental degradation and social injustice)

He discusses the disturbing shifts created by a complex of factors such as the rise in screen-based entertainment and increased parental fear of unregulated spaces. He observes that whilst children may be aware of global threats to the environment, their close contact with nature is fading…"[they] can likely tell you about the Amazon rain forest – but not about the last time he or she explored the woods in solitude, or lay in a field listening to the wind and watching the stars move."

Louv also contends that respect for the planet and a passion for sustainability and environmental activism are often borne out of the intimate contact with nature that has been so eroded.
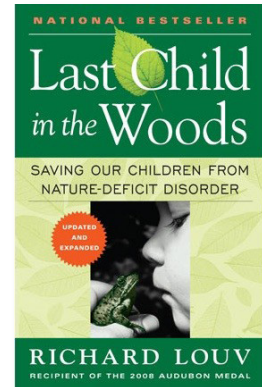
The settings approach

Having briefly set out the context for connecting health, sustainability and social justice agendas in relation to people and planet, I now want to shift the focus onto 'place' by looking at what's become known as the 'settings approach'.

We all spend time in a range of different places and it's clear that they have important influences on our wellbeing. Settings such as schools and workplaces have long been used by health promotion professionals as convenient vehicles for targeting interventions.

Understood in this way, settings – together with population groups and health topics or problems – make up the traditional three-dimensional matrix used to organise health promotion programmes, particularly those concerned with encouraging individual behaviour change.

However, what's become known as the 'settings approach' moves beyond this fairly mechanistic view, appreciating that the contexts or places in which people live their lives are themselves crucially important in determining health.

The settings approach has developed over nearly 30 years to become a key element of health promotion strategy at local, national and international levels.

It has its roots within WHO's Health for All strategy and, more specifically, the Ottawa Charter, which contended that: "health is created and lived by people within the settings of their everyday life; where they learn, work, play and love…Health is created by…ensuring that the society one lives in creates conditions that allow the attainment of health by all its members."

Subsequent conferences and declarations further legitimized the approach, affirming that particular settings offer an effective infrastructure for the implementation of comprehensive strategies for health promotion – as witnessed by an expanding range of programmes, networks and strategies covering a diversity of settings.

Reflecting on this expansion, Ilona Kickbusch has commented that the 'settings approach' became during

the 1990s the starting point for WHO's lead health promotion programmes, which involved a shift of focus from the deficit model of disease to 'salutogenesis', concerned to foster the health potentials inherent in the social and institutional settings of everyday life – and so support wellbeing and human flourishing.

Whilst the WHO glossary defined a 'setting for health' as the social context in which people interact to affect wellbeing and create or solve problems relating to health – it's also clear that most settings are in reality oriented to goals other than health and have pre-existing structures, policies, characteristics and institutional values.

It follows that the settings approach involves:

- a focus on structure and agency (and place and people)

- an understanding of a setting not only as a medium for reaching 'captive audiences' but also as a context that directly and indirectly impacts wellbeing; and

- a commitment to integrating health within the culture, structures and routine life of settings.

So why use the approach?

Whilst the provision of 'health' services is vitally important, our health is largely determined by social, economic, environmental, organisational and cultural circumstances – which directly impact wellbeing and also have indirect influences through providing more or less supportive contexts within which people make lifestyle choices.

It follows that effective health promotion and improvement requires investment in the places in which people live their lives.

More specifically, the approach recognises that people's lives are complex and that the processes of enabling human flourishing and addressing 21st century health challenges are equally complex – requiring us to engage with what's been characterised as 'wicked' problems.

Complexity requires us to embrace holism and emergence, appreciating that the patterns and system-related behaviours relating to these challenges are not predictable, are not linear and cannot be understood through reductionist analysis.

This means that the underlying influencing factors and conditions are interrelated and can be most effectively tackled not by 'single thread' interventions, but through comprehensive, integrated programmes in the settings of everyday life – where people learn, work, play, love, live and die.

Overarching characteristics

Conceptually, the settings approach is rooted in health promotion values such as equity, partnership, participation and empowerment – and has three overarching characteristics.

Firstly, it adopts an ecological model. It appreciates that health is multi-layered and determined by a complex

Some big challenges for health promotion (including the "converging crises" of environmental degradation and social injustice)

interaction of factors; it focuses on populations within particular contexts; it represents a shift of focus towards an holistic and salutogenic view; and it addresses human health within the context of ecosystem health.

Secondly, the approach views settings as complex systems, acknowledging interconnectedness and synergy between different components, and recognising that each setting is connected to the world around it.

Thirdly, the approach adopts a whole system focus, drawing on learning from organisation and community development and using multiple, interconnected interventions to embed health within the culture and ethos of settings that generally do not have health as their 'raîson d'être'.

This means harnessing the multi-dimensional nature of settings – and, within this, the relationship between the structural dimension provided by their contexts, facilities, services and programmes, and the human agency of the people within them – to create healthy, supportive and sustainable environments; integrate health into routine life and core business (whether this is quality of patient care in hospitals; education in schools; or rehabilitation in prisons); and connect with and contribute to the wellbeing of the wider community.

This model illustrates the balances involved in implementing a whole system approach. It reminds us that the approach is underpinned by core health promotion values, draws on a diverse portfolio of methods and involves holding a number of aspects in tension: addressing needs and problems, but also seeking to celebrate and build on strengths and capabilities; investing in long-term 'behind the scenes' organization development, but retaining a high profile through managing innovative and visible projects; securing top-down leadership alongside bottom-up empowerment and broad-based ownership; and anticipating and responding to public health concerns whilst also being driven by and contributing to mainstream business.

Lessons since the Ottawa Charter

Having outlined the background to, set out the rationale for, and sketched a conceptual framework for understanding and implementing the settings approach, I want to step back and consider what we've learnt in the decades since the Ottawa Charter.

The first lesson is that there is a diversity of activity happening under the banner of what is variously labelled settings-based health promotion, health promoting settings, healthy settings and settings for health.

Whilst diversity can be a strength, it can also indicate a lack of clarity, which this varied terminology perhaps symbolises. I'd suggest that it also reflects a tendency to shy away from, rather than embrace, complexity.

In their 2001 paper, Sandy Whitelaw and colleagues presented a typology of different models of settings activity. Whilst they acknowledge that it is not always possible to implement a fully comprehensive approach, they support Wenzel's earlier critique, arguing that those claiming the settings label need to do more than repackage interventions focused on individual behaviour change – a view reinforced by Johnson and Baum in relation to health promoting hospitals.

The second lesson is that whilst there is value in articulating an overarching framework to guide

Some big challenges for health promotion (including the "converging crises" of environmental degradation and social injustice)

implementation, settings are not all the same and exist in relation to each other. When we talk about a 'health promoting school', a small primary school presents very different challenges to a large secondary school; and when we talk about workplaces, we not only have to consider businesses ranging from small and medium enterprises to huge multinationals, but also how workplace health is addressed as a crucial feature of our programmes in healthcare, educational, criminal justice, leisure and other settings.

Furthermore, there are clear differences between categories of settings – for example institutions such as hospitals and universities are very different from less formal 'geographical' settings such as neighbourhoods and homes, yet all of these are nested within – and contribute to the wellbeing of – cities, towns and municipalities.

The third lesson is that the settings approach risks reinforcing power imbalances and perpetuating inequalities – and it is important to engage critically with the structure and agency debate.

Green, Poland and Rootman caution against programmes uncritically aligning themselves with management: whilst the approval and commitment of such gatekeepers may be important in gaining access to a setting and influencing organisational change, it may unintentionally play into existing power relations and make it difficult to engage and gain the trust of other stakeholders.

They also echo Galbally in drawing attention to the danger that by focusing on well-defined organizational settings, we miss many of the most vulnerable and disenfranchised groups of the population – such as the unemployed, the homeless, asylum seekers and children who are excluded from school.

This highlights the importance of further developing work with settings such as prisons and children's care homes, and of locating settings-focused work within the context of a broader health promotion framework – it's only part of the solution!

And the fourth lesson is that health is closely related to other agendas and concerns and that there is value in moving beyond the boundaries of traditional health promotion.

This realization is one that I've already highlighted in the context for my presentation and one that has become increasingly apparent in the context of globalization and in discussions about 'liveability.'

For example, the report Our Cities, Our Future reflected that "liveability refers to the way the… environment supports the quality of life and wellbeing of communities. Quality of life and wellbeing encompasses mental and physical health, happiness and life satisfaction for individuals and supportive social relationships in communities…[and] is enhanced by environmental sustainability."

In responding to this learning, I'd suggest that we need to reflect on our experience to date and forge a new praxis for healthy, sustainable and connected settings that is holistic and integrated. So, what are the implications?

A call to clarify values and theory

Some big challenges for health promotion (including the "converging crises" of environmental degradation and social injustice)

First, it means 'connecting practice, theory and research'. When undertaking my doctoral study, many of those involved in the emergence of healthy settings reflected that, whilst informed by ecology, holism, salutogenesis and systems thinking, the approach has lacked a theoretical framework – a concern that Jane Wills, Jo Newton and I will be exploring in a workshop following this session.

I'd suggest that we can strengthen practice and implementation through clarifying both values and theory – and that we need to be explicit about what our settings initiative is aiming to achieve and how we expect this initiative and its multiple interventions to achieve those aims.

Closely linked to this, we need to find ways to move beyond evaluating the individual interventions taking place in a setting, to capture the added value of adopting and implementing an ecological whole system approach.

Whilst there have been calls to move beyond linear evaluation and engage with complexity through utilising realist and theory-based approaches, there are still relatively few examples of research that has successfully grasped this 'nettle'.

Second, it means 'connecting within' the setting. Specifically, this will require us to connect top-down leadership with bottom-up participation … daring to combine senior leadership with unleashing the richness of grassroots creativity and innovation – ensuring that, in the words of Ilona Kickbusch, "settings provide a political space for empowerment."

More generally, it will mean appreciating and mapping the linkages that exist in any one setting. To illustrate this with reference to a school, our focus might be on connecting between… different groups of people or different topics or issues or different components of the system.

Third, it means 'connecting outwards', appreciating that settings are interlinked. People's lives straddle different settings – both at a specific point in time and, as Dean Whitehead has discussed, across the life course.

Similarly, the 21st century challenges facing us – such as climate change and obesity – do not respect boundaries. Furthermore, these boundaries have become increasingly permeable: a problem made manifest in one setting may well have its roots in a different setting which, in the case of an issue such as bullying in school, is increasingly likely to be virtual or online as well as within the geographical community.

Connecting settings with wider systems

This means that there is value in connecting settings with their wider systems – appreciating that initiatives with discrete settings can be a springboard for expanding the work, for example from health promoting schools and health promoting hospitals…

…to health promoting kindergartens and universities and health promoting health and social care services.

Settings also exist at different levels, often within the context of each other. For example, a hospital or school may be within a particular neighbourhood, within a town or city, within a district, region or island, within a country – with the planet being the overarching contextual setting.

Some big challenges for health promotion (including the "converging crises" of environmental degradation and social injustice)

This echoes Bronfenbrenner's work on social ecology, in which he suggests that human development takes place in micro, meso and macro settings within a number of interconnected layers.

This understanding reinforces the need for settings initiatives to respect and care for the earth – but also has implications for the conceptual and practical organization of different programmes.

In one of my interviews, Agis Tsouros from the WHO Regional Office for Europe said "a Healthy City should be a city of healthy settings," highlighting the need to view individual settings as part of a bigger whole and work to enhance the synergy between them and maximise their contribution to the well-being of municipalities.

Whilst we can make some progress developing a 'whole system' healthy and sustainable food strategy or travel plan for a specific setting such as a hospital or a university, a truly holistic approach demands that we have joined-up strategies across settings.

However, whilst certain WHO regions have at times worked with 'families' of settings within the overarching frameworks offered by Healthy Cities, Healthy Districts or Healthy Islands, bureaucratic structures and competing egos have too often intervened and stopped this from happening.

Fourth, it means 'connecting upwards' – acknowledging that whilst action focused within and across settings is important, there are higher level influences at play.

In looking upwards, we can examine our work to ensure that it is doing all it can to tackle the wider determinants of health and ill-health – and integrate health equity impact assessment into our planning and delivery of settings programmes, as was urged in the final report of the Commission on Social Determinants of Health.

Beyond this, however, part of our task must be advocacy – calling on governments, multi-nationals and global organizations to act for health, sustainability and social justice.

And fifth, an holistic approach also means 'connecting beyond health' – explicitly linking the health of people and the health of the planet, and prioritizing and using as exemplars place-based actions that engage with both health and sustainability concerns.

I want to pick up on this last point and revisit the territory that I touched on at the start of my presentation – considering why we should connect health and sustainability in relation to settings. I'd suggest that there are at least three reasons…

First, health is both a critical outcome of and prerequisite for environmentally, socially and economically sustainable development – and we are most likely to see healthy and sustainable settings when we do not view economic development as an end in itself, but hold these three spheres of action in balance, promoting places that are viable, liveable and equitable.

Second, the causes and manifestations of unsustainable development and poor health are interrelated, pose

Some big challenges for health promotion (including the "converging crises" of environmental degradation and social injustice)

interconnected challenges and offer potential for 'win-win' synergistic solutions. For example, there is enormous synergy between climate change and obesity…

This relates both to their roots in underpinning metabolic imbalance and in the range of actions and policy interventions that can be taken to tackle both, with wider knock-on effects.

Thus, good spatial planning catalysed by Healthy City initiatives can increase levels of physical activity and increase access to healthy and locally-produced food, which in turn can help to tackle obesity and non-communicable diseases; enhance mental wellbeing; and reduce carbon emissions through decreased car use and lower food miles.

Third, the health of people, places and the planet are interdependent. This can be understood in a number of ways: for example, as I've already highlighted, there is a growing body of evidence demonstrating the positive impacts of nature and green space on human wellbeing; and there is likewise a wealth of research showing how the deterioration of 'planetary health' poses significant risks to the health of people.

In advocating for ecological public health, Tim Lang and Geof Rayner argue convincingly that "the interface of human and ecosystems health now deserves to be central for policy making."

Picking up this last point, it's widely acknowledged that we face a significant 'triple threat' from environmental degradation, climate change and resource depletion.

This threat is closely connected to societal greed and to a continued infatuation with unfettered growth (which begs the question for many as to whether we can coherently link the words 'sustainable' and 'development').

Relating these concerns to health, we also know that increased material wealth does not automatically translate into increased wellbeing – and Phil Hanlon from Glasgow University has highlighted the threat that consumer culture poses to both humans and the long-term sustainability of the planet – suggesting that the public health community has a vital role to play in working creatively to imagine and bring about an approach that enables us to 'use less stuff' and have better health and wellbeing.

It's also clear that these threats contribute to and are closely entwined with growing socio-economic inequalities, poor health status and increasing inequities in health – making it imperative that policies for health and sustainability are integrated and that social justice is understood to be inextricably linked to environmental justice.

So, what have the responses been?

At an individual level, we've seen an increasing market for 'green consumerism' and a concern with reducing 'carbon footprints'.

At community and city levels, there has been a growing focus on activism and mobilisation, often around specific issues.

At an organisational level, there has been a surge in the development of frameworks and standards for corporate

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environmental (and social) responsibility in a diversity of settings – accompanied by expanding rhetoric and action concerned to promote sustainability through 'greening' organisational behaviour, whilst increasing productivity and securing a market advantage.

These responses have evidently led to what can be termed the 'greening' of settings through institutional practices and community and city-level governance related to a range of issues.

Ecological determinants on the sidelines?

However, I'd suggest that health promotion has tended to focus so strongly on social determinants of health that ecological determinants risk being sidelined.

Despite a growing appreciation of the health benefits of increased access to nature, and of carbon reduction and climate change mitigation and adaptation, action for 'sustainability' and 'health' have tended to happen in parallel – perpetuating what Trevor Hancock has called a 'multiple-silo' approach.

Furthermore, many 'greening' initiatives, like many health promotion initiatives, tend to be 'add-ons', delivering fragmented lifestyle interventions within settings rather than reflecting an ecological whole system approach.

Before concluding, I want to expand on some work I did with Blake Poland to suggest some principles for practice that could underpin an holistic and integrated approach to creating healthy, sustainable and connected settings.

Take a positive look to the future

First, dare to envision the future we want – adopting an ecological perspective and identifying what makes places liveable, vibrant and enriching, then taking this diagnosis and applying it to the settings of everyday life.

In doing this, we may need to let go of the explicit language of health – but may find new ways to facilitate innovative and creative change and help build sustainable and connected settings that enhance human and ecosystem wellbeing.

Second, whilst holding on to this 'big' vision of what healthy and sustainable settings can and should be, take smaller incremental steps towards realizing that vision – finding 'entry points' where we can secure both top-down commitment and bottom-up engagement.

Third, start where people are…This means listening to and respecting people and negotiating agendas, balancing the urgency of our priorities with a willingness to value other concerns and build shared ownership – and understanding that different people see the world through different 'lenses'.

Fourth, build on strengths and successes…this means looking for assets and capacities within communities and organisations, rather than focusing only on needs and deficits – and learning from, harnessing and connecting the things that are already working effectively.

Fifth, root practice in place… this means that whilst the settings approach seeks to stay true to common values

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and characteristics, it also appreciates the distinctiveness of different settings and the need to take account of different cultures, structures and histories when we develop and implement initiatives – as highlighted by Poland, Krupa and McCall in their framework designed to guide design and delivery.

Sixth, build resilience within and between settings – recognising that narrowly-defined notions of efficiency have often led to its erosion. This focus is prominent in grassroots initiatives such as Transition Towns, and leads on to the next principle…

…which is to engage with and learn from emerging social movements.

Looking back at the literature in the immediate aftermath of the Ottawa Charter, settings-focused programmes such as Healthy Cities were talked about as new and exciting social movements for health…

Twenty years on, they are, arguably, at risk of becoming institutionalised, professionalised and bureaucratised – and I'd suggest that we need to step outside of our comfort zone and engage with and learn from the movements for social justice, sustainable futures and community resilience that have truly become 'viral', such as Transition Towns and Occupy.

These have clearly captured people's imagination and tapped into the zeitgeist or spirit of the age – and are where some of the most exciting change is happening. There's huge potential for us to build partnerships to tackle some of our most taxing issues.

Last, revisiting the importance of advocacy, we need to deepen our socio-political analysis… this means shifting our focus beyond symptoms to root causes; and at the same time supporting processes akin to what Paolo Freire called 'conscientisation' – working with stakeholders and communities within and across different settings to enable them to develop critical consciousness about the wider determinants of health, sustainability and injustice; to connect their lived experience to that of others and to the wider practices and structures that create and sustain exploitation of people and the world around us; and to become empowered to realize their agency and to advocate for and catalyse change.

To conclude…I've argued that – more than a quarter of a century after it was ushered in by the Ottawa Charter – the settings approach is still highly relevant and can make an important contribution to health, sustainability and liveability.

By adopting an holistic, integrated and connected approach, we have the potential to respond to the lessons we've learnt and the 21st century challenges we face – enhancing the relevance and effectiveness of initiatives in the diverse places in which people live their lives.

Isis Brook, formerly at UCLan, talks of the importance of "healing ourselves of our current alienation from nature and healing the earth from our alienated actions upon it."

Some big challenges for health promotion (including the "converging crises" of environmental degradation and social injustice)

As the converging crises of environmental degradation, climate change, resource depletion and social injustice intensify, we will need to do more than 'tick the right boxes' – daring to envision a different future and to change the way we conceptualise, organise and live our individual, community and working lives.

In looking to such a future, it will be important to focus not only on the negatives – the very real risks and 'doom and gloom'; but also on the positives – re-engaging with the environment and the wonder of the world around us; and recognizing that within upheaval lie the seeds of hope and empowerment, and the potential for us to engage and embrace the emergence of new possibilities for enhancing the wellbeing of place, people and planet.

Helping to nurture and midwife this transition is perhaps the most important task facing health promotion today.

A Croakey #LongRead: remembering those we've lost – and a call to action for planetary health

The week that this article was published marked the first anniversary of the **traumatic loss** of **Professor Gavin Mooney** and his partner **Dr Delys Weston**.

The lengthy article below captures some of the themes from **a conference** that honoured their work and their activism for a fairer, more sustainable world.

It is followed by a remarkable **cri de coeur** from **Siobhan Harpur**, Director of Population Health Operations for the Tasmanian Department of Health and Human Services.

She urges us to seize our "individual and collective responsibility to make a difference". Reading her speech is a good place to start.

. . . .

"We need new ways…"

At a recent forum in Hobart, leading public health experts painted a grim picture of the state of planetary health, warning of eco-collapse and growing inequalities.

Associate Professor Peter Sainsbury, of the University of Sydney, told the forum that humanity is in "a mess of our own making", which threatens the future of our species.

"I'm very pessimistic there will be anything more than very rudimentary human life on this planet in 200 years time," he said.

Sainsbury said that this mess of "unprecedented proportions" had arisen because humanity had ignored that we're part of part of complex, adaptive ecosystems and that we live in a world of finite resources, and because we had failed to learn from what science tells us.

"This emphasis on 'me', here and now, this disregard for people elsewhere and future generations – this is a failure of morality," he said. "This is clearly manifest by the inability of western democratic governments to see a way through.

"We need new ways of collective decision-making that are responsive, inclusive, and that include minorities, not just the majorities, and that create maximum harmony."

Associate Professor Marilyn Wise, from the University of NSW, stressed the importance of ensuring that those groups who traditionally missed out were represented in decision-making within institutions, organisations and governments.

"We need to share power, create spaces, conversations, examine our own institutions and look at how they are perpetuating old ways of thinking," she said. "We always need to ask who's in the room when decisions are being made."

The forum, "Our health – who decides", was convened by **Tasmania's Social Determinants of Health Advocacy Network** to honour the memories of the late Professor Gavin Mooney (a prolific Croakey contributor), his partner Dr Del Weston, and also Ms Linda Jamieson, an advocate for the rights of older Tasmanians.

There were few dry eyes as we heard courageous presentations from Weston's children – lawyer **Katherine Weston** and community development student **Alex Soares**.

Their talks, which cannot be reported, were a powerful reminder of the toll that mental illness and unresponsive services take upon families and communities.

The forum also heard a strong presentation on the economic and political drivers of health inequities from **Professor Sharon Friel**, Professor of Health Equity at the ANU.

Like Mooney, Friel grew up in Glasgow, and shared his outrage at the "completely avoidable injustices" that continue to occur in that city (as shown in variations in life expectancy between rich and poor areas) and elsewhere in the world.

She described the "structural pathologies" that contribute to health inequities by shaping peoples' everyday living conditions, including access to a healthy food supply.

The major drivers of an unhealthy food supply are unfettered liberalisation of international food trade, increased foreign direct investment, and globalised advertising and marketing, she said.

Friel added that Coca Cola is more easily available than water in some countries in Africa, and that for low and middle income countries, having a Free Trade Agreement with the US was associated with increased soft drink consumption.

Friel also described how the Trans Pacific Partnership trade and investment agreement that is currently under negotiation may limit governments' ability to regulate industries that manufacture and market products that are potentially harmful to health – such as the tobacco, alcohol and processed food industries.

Friel said:

Governments need to be able to raise the prices of unhealthy goods, to restrict marketing and advertising, sale and distribution, and to regulate labelling of these products.

We want to, for example, retain the ability to put warnings on alcohol products, or to introduce new rules around nutrition labelling for food.

croakey

But many parts of the TPP could allow the private sector to meddle in government policy, and restrict the flexibility – or policy space – for governments to be able to set and implement these important public health policies."

Friel said Mooney wrote about how to create just, fair and compassionate institutions in the face of neoliberalism and injustices in the distribution of money, resources, and power.

"He writes about reclaiming power," said Friel. "We need to celebrate the fact that it can be done."

Indeed, the two-day event was marked by duelling themes of light and dark – and of people power mustering against unjust institutions and political systems.

One of the conference organisers, **Miriam Herzfeld**, noted that while the gathering had arisen out of sadness at the traumatic loss of friends, it was also about looking to a future filled with activism and a commitment to tackling the big and difficult issues.

This dualism was powerfully captured in a very personal speech from one of the forum's organisers, Siobhan Harpur, Director of Population Health Operations for the Tasmanian Department of Health and Human Services, reproduced in the following article.

In this sometimes dark world….what is the inspiration that we can find for a brighter future?

PUBLISHED: **December 16, 2013**

BY: **Siobhan Harpur**

I will share with you some my own personal reflections – some of them are dark observations that sit beside the hope that I have for a brighter future.

What right do we have to ownership of the earth and its resources? The earth's resources, economic, social, the land itself – the split between ourselves and people who are much poorer than ourselves, the split between ourselves and those of future generations who may not have what we have because we have used so much of the collective entitlement up.

This observation is true for our care of the earth itself, and it is also a reflection of our relationship to money and to power; to democracy and the fundamentals of civil society.

We have been captured by individualism. We have been captivated by the comforts, the conveniences and opportunities that the system has offered. We have had too much to lose, and we have refused to see.

The extraordinary success of the system for so many of us individually has blinded us to its failure to care for the whole. I have been told that I am too unrealistic in my expectations, too much of a purist. It is impractical, they say, to expect too much of large organisations and contemporary society.

I challenge this limiting view and say that we can tread gently, treat people kindly and live simply. And I know that I am not alone.

We are the stewards and the custodians – the temporary beneficiaries of this land we stand on and the life we have been given – our responsibility is to work with it, to do our very best to pass it on in an improved condition to our future generations. To put it simply we should take responsibility for "paying it forward".

If our values are not fundamental to the way we see society more broadly, then how can we expect to see them in our organisations?

In this sometimes dark world….what is the inspiration that we can find for a brighter future?

I invite you to come with me. I stand here today because I am challenging myself to personally to share my truth. I look to that of good in everyone, and an interconnectedness that surpasses people and extends to all living things. I am challenged by this personally, professionally and spiritually.

These are not new thoughts. When I was at primary school my friend Billy and I used to talk about running away to visit the zoo. I knew there were separate rules for those of us who lived at the top of the hill, and my friend Billy lived at the bottom, so I took the initiative and stole two bicycles in order for us to get there faster.

The result – without sharing all of the adventure that ended with us being brought back by the police – was that the headmaster spoke to me about responsibility and modifying my behaviour, and Billy got the cane in front of the rest of the school the following morning.

In the last 50 years we have lived through a period of extraordinary growth built on debt, and which has given free market globalisation its veneer of success. I was fascinated by the loss of the gold standard when I was at school and its implications.

And now, money, and even gold itself, has become its own commodity, trading in currency fuelled by speculation and no longer linked to goods and services, which are themselves fuelled by a rampant consumerism that more and new is always better than making do with what we have.

Poverty kills people and here and now thousands of people are dying prematurely or unnecessarily. There are 97,000 people living in poverty in Tasmania, which is one fifth of our population.

I am shocked that the difference in life span in Australia today is predicted at birth to be as much as 15 years shorter for an Indigenous or Aboriginal person, and 10 years between the wealthiest and the least wealthy in society generally. So many people in generational difficulty.

It is by leaning into this pain and suffering that I can foster my own compassion.

What is it that I am responsible for, and what am I complicit in not challenging?

When I ask the question who makes the decisions about my health, I am reminded that international corporations are influential, and outside of my control, or even the control of the State or National Governments.

Picture, for example, the action by Coca Cola Amatil in the Tiwi Islands. (Coca Cola itself was started by the company British American Tobacco – but that's an older story). The Islanders were supported in their campaign to ban the sales of Coca Cola in their general stores, and then shocked when Coca Cola Amatil negotiated directly with individual citizens to install vending machines on peoples' decks.

That population with its high incidence of type 2 diabetes, was making a stand to invest in preventable action, and it was thwarted with the action of a powerful multi national. Big pharma, big food, big banks – they are here and now and we can acknowledge the facts – whatever my level of education and income, where I live will impact on my health because I may not have the access to making healthy choices in what I eat, how I live, or whether my children can play safely.

In Tasmania we know that there are many food "deserts" – identifiable places where there is little or no access to fresh fruit or vegetables for sale within a reasonable distance from your home.

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But most places have access to a takeaway with a deep fryer, and the answers are not simply giving people fresh food.

Just like by friend Billy who didn't choose to live at the bottom of the hill.

The world is more complex and we appreciate that there are many more competing forces, and everything happens instantly, especially globally.

But we can't keep hoping for a gold class standard public system without paying more than the equivalent value of a 20 year old Holden for it. But we can look together at what we have, and consider how we can use this precious investment wisely and effectively so that it can be much better. Especially how it can be more equitable.

If I squeeze my values into a very narrow area of spirituality that doesn't deal with public life, I am denying the very opportunity of life itself. Living life honestly, with integrity, questioning and reflecting on our actions, speaking truth to power.

Like many of you at this Conference, my faith and confidence were shattered on the 19th of December 2012 when Gavin Mooney and Del Watson so tragically died at Mountain River.

I would describe myself as a reluctant leader, increasingly coming to terms with this perhaps being my leading, and confirmed very deeply in the brief friendship that we made as a family with Gavin and Del during the 18 months they were here.

Gavin encouraged me to feel proud to be in public service, reminding me often that it is a most important job.

I have been thinking about how I can be more effective and influence what is possible as I find myself meeting head on all of the challenges of living in this complex world. I know that by challenging ourselves in the decisions and choices that we make every day, and throughout each day is not only more meaningful and rewarding, it also offers the real and tangible opportunity for a brighter future for all Tasmanians.

What is that you will bring of yourself, what is your commitment?

There is three times as much mental distress experienced by people who have less power in their own lives. And it isn't just about income, it is about equity.

The person with an intellectual disability or impairment whose behaviour brings them into the criminal justice system. Someone with a mental illness who ends up homeless and struggles to settle in accommodation of any sort long term. Or another person with the experience of trauma or abuse who has turned to alcohol or drugs as a coping mechanism.

Any or all of these people may need help to find work and support for themselves and their families. We have both an individual and a collective responsibility to make a difference. I have a passion for creative innovation and bringing out the very best in people and in my job as a Director in Population Health inside Government I am committed to improving the health, social and economic outcomes for people and communities.

One of the theoretical arguments for change is that there needs to be a burning platform before people will want something different enough to jump from what they are used to, to an unknown future. Isn't that the very basis of trust and belief?

In this sometimes dark world….what is the inspiration that we can find for a brighter future?

All systems can change and are transient. Everything has its time. And the time for action is now. The social and economic consequences of doing nothing to challenge and to question are huge – increased suicide, people in prison, obesity, homelessness, risky use and violence as a result of drugs and alcohol, crime, low literacy. We are paying this price now, and we should not be silent about it.

The biggest difference that we can make is to provide meaningful work for all. Fulfilment and self worth have an economic and social consequence that has a health outcome. Putting values into action is not a unique conversation in community sector organisations or the public service. There are increasingly enlightening board rooms as executive and non executive directors realise that the focus on risk reduction and financial return is not enough to truly succeed in business and create wealth overall.

We can do so much here in Tasmania, and we have the advantage of our size and agility, and all of our relationships. We can re build trust in business by enabling small and new enterprises to grow, especially worker owned, cooperatives, partnerships, social enterprises, business that is creating wealth and is founded on values of integrity, fairness and exchange.

Change starts with me. I am both incredibly important, at the same time as being of absolutely no consequence at all.

What I realise, and what I endeavour to make sense of every day in my work, and in my encounters with people, is that every encounter matters. Where people feel humiliated, afraid, ashamed, and unwanted – these experiences are passed on through other encounters.

Where people experience respect and acknowledgement, this too holds the possibility for change. And big changes happen because of the actions of individuals.

There is an urgent argument for all of us individually and within our families, our neighbourhoods, our workplaces, work teams, organisations, businesses, schools and communities – to invest our time and effort for a brighter future. We can claim health as a resource for living. We can trust in the capability of one another.

So I invite you to come to the table with curiosity, and bring your friends and colleagues – including those you don't yet know – let's listen to new perspectives and find new solutions together. It doesn't matter where we have come from, or what we bring with us, what matters is how we go forward together.

The opportunities that we can make with one another if we hold our hearts open with compassion, the knowledge that each person and each living thing is of good intent, gives us the courage to be with each person, in service each day.

• Siobhan Harpur manages 100 staff across the health protection and health promotion responsibilities of Public and Environmental Health, and Population Health and Wellbeing Services in Tasmania. She also has an additional leadership responsibility for the State Government commitment for preventive health – called a Healthy Tasmania. The picture above was taken when she climbed Cradle Mountain in 2012.

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#CripCroakey: why the 'problem' of housing for people with disability is one for everyone

In this article for the crowd-funded **#CripCroakey** series, El Gibbs looks at why there seems to be a sudden 'problem' of where people with disability will live in the future.

She asks what exactly is this problem?

> *Is it an affordable, accessible housing problem? Or a care and support problem? Or does it expose a deep ambivalence, or even hostility, to having people with disability living in the community? I suspect it's a combination of all these factors.*
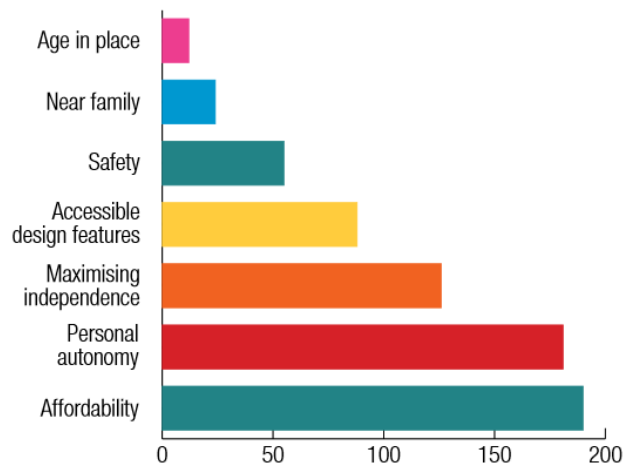
The big mistake, she says, is in continuing to believe that people with disability need 'special' housing. In fact, they need the same kind of housing as everyone else: affordable and accessible, safe and secure, and close to services and jobs.

And therein lies the problem, with affordable housing pretty much off the agenda in federal politics, and state governments winding back on public housing provision and maintenance.

Gibbs says this chronic and urgent lack of affordable housing is "perhaps a chance for disability and housing groups to work together, to create coalitions, to push for change that will truly realise the vision of people with disability being included and part of the community".

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El Gibbs writes:

People with disability need somewhere to live, just like everyone else. They need a place to call home, have friends over, spend time with the people they love, be safe and secure. The UN **Convention on the Rights of Persons with Disabilities** (Article 19), to which Australia is signatory, makes this clear, saying that people should "have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement."

Having a home that is safe, secure, affordable and accessible shouldn't be a luxury only for the rich. Rising inequality in Australian can be directly linked with the **growing divide** between those who own a home and those who don't.

Bringing people with disability into the community means that they will share in existing community systems and structures, including those, like our housing system, that aren't working.

Recently, there have been many **headlines** and discussions about the sudden 'problem' of where people with disability will live in the future. But what exactly is this problem? Is it an affordable, accessible housing problem? Or a care and support problem? Or does it expose a deep ambivalence, or even hostility, to having people with disability living in the community? I suspect it's a combination of all these factors.

CripCroakey: why the 'problem' of housing for people with disability is one for everyone

Can't afford housing

As I outlined in the last **#CripCroakey** article, there's a substantial shift going on in disability policy with the introduction of the National Disability Strategy and the National Disability Insurance Scheme to a more rights-based approach that includes living in the community and accessing mainstream services. This means that these services, both public and private, do need to change.

The **Strategy** found that "there is evidence that people with disability experience substantial barriers in finding a place to live, especially in the private market", and flagged housing as one of the areas that all governments need to improve for people with disability.

MY HOUSING GOALS

Goal	Value
Age in place	~10
Near family	~22
Safety	~55
Accessible design features	~90
Maximising independence	~125
Personal autonomy	~180
Affordability	~190

Housing affordability is not just an issue for people with disabilities – it is a problem across Australia, particularly in capital cities. In recent decades, housing has become more about making money that having a home. Media has been full of reality shows about renovations and gasping articles about huge rises in the costs of owning a home. At the same time, **government policies**, such as first home buyers grants, negative gearing and capital gains tax concessions have fuelled this acceleration in house prices, while ignoring people who rent or live in other kinds of housing.

Tenancy law has **little security** to offer those who rent a home, with limited leases, an inability to make modifications, no-cause evictions and no cap on rental increases. Governments across Australia have been selling off public housing and not replacing it, while waiting lists balloon. Already, people with disability are **more likely** to live in public or social housing, less likely to own their own home and are in housing stress (defined as paying more than 30% of income on housing costs.).

Policy wasn't always like this – previous governments built public housing because they recognised that **housing was more than a way to make money**. But also because they understood that just treating housing as a market meant that people would miss out on having somewhere decent to live.

croakey

CripCroakey: why the 'problem' of housing for people with disability is one for everyone

Housing stress is rising: National Shelter, the peak housing advocacy body, has found that some **families are paying 65 per cent** of their income on rent. The average **household income** needed to now buy a house is as high as $100,000 in some cities. As housing has become more expensive, affordable housing has been occupied by people on higher incomes, pushing people on low incomes further and further away.

Many people with disability live in poverty, particularly those on Newstart and Disability Support Pension. Anglicare's **affordable rental snapshot**, done yearly in April, shows that there is nowhere to rent in major cities for anyone on Newstart, and only 0.1 per cent of 51,357 surveyed rental properties are affordable for someone eligible for the disability support pension. For people relying on Centrelink payments to survive, there is nowhere to live that is near services or jobs. The booming housing market hasn't included everyone.

So the 'problem' of disability housing is not separate from the problem of affordable housing – in fact, it is the same problem.

Can't stick with old models

The roll-out of the NDIS is predicted to lead to an **extra 122,000** people entering the Sydney housing market alone, looking for affordable and accessible homes. The NDIS model of individualised disability support means that many people with disabilities can have some choice about where they live, without having to go without the support they need.

Every Australian Counts (EAC), the campaign organisation for the NDIS, released a **housing discussion paper** at the end of 2015. It found that there was a great deal of concern from older parents about what would happen to their adult children with disabilities and that there were nearly 7,000 people under 65 years living in aged care facilities. The paper also found that, overwhelmingly, people with disability wanted to live on their own or with peers, just like everyone else.

The EAC sees a role for the NDIS in funding innovative housing models despite the fact that the NDIS was designed to provide disability support only. The National Disability Strategy emphasises that people with disability should be accessing mainstream services, such as housing. Creating a separate tranche of housing, that is just for people with disability, would only continue outdated segregation models that deserve to go the way of the dinosaurs. It would also take the pressure off state, territory and Federal governments to finally get serious about affordable housing.

CURRENT HOUSING CIRCUMSTANCES
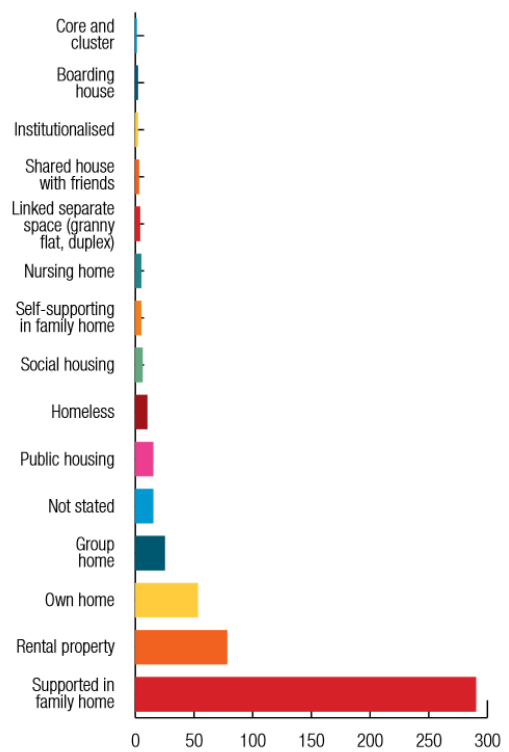
Can't get into it

For many people with disabilities, housing is not accessible but that does not point to 'separate' housing styles. Accessible housing is good for everyone, as most people will be disabled at some stage of their lives. And yet, Australia has no mandatory system to ensure that even new housing is built with accessibility in mind.

Voluntary **guidelines** exists that recommend wider hallways and doors, space in bathrooms to add grab rails, hoists and seating, adjustable bench tops and a ground floor toilet. Instead, these are seen as an **imposition** that will make housing more expensive, instead of as something that needs to be integral in housing design. I'm sure windows also add to housing costs, but they are not seen as an optional extra.

It's also about more than just your own home: this lack of accessibility also applies to the houses of friends and family, making socialising more difficult.

This refusal to mandate even minor accessibility features shows how invisible disabled people are from the mainstream and actively shut out people that are 'other' than normal, 'other' than included, 'other' than part of the community.

Can't get supported in it

Disability housing has a history that is full of dark shadows of **neglect**, **segregation** and failure. For decades, people with disability were put in institutions. These were large centres that were often place in areas well away from the community. The rise of the disability rights movement in the 1970s and 80s challenged segregation and championed the rights of disabled people to live in the community instead. The Disability Services Act in 1986 clearly **outlined a pathway** to de-institutionalisation, a process now knows as devolution to the community.

This closure of institutions has however often not been matched by making housing more available in the community or the provision of services. A million reports have been written about this since de-institutionalisation began, all calling for more **affordable and accessible housing** to be made available, and showing that support in the community works better and is more affordable. This gap in disability support – between institutionalisation and community living – is not a new one, but is becoming more visible with the implementation of the NDIS.

Many people with disabilities only receive support because of where they live. Personal care, such as eating and washing, medical and dental care, recreation and socialising are often dependent on living in a group home or an institution. Imagine that you could only see a doctor, or have something to eat, if you live in a certain place. Imagine that you are forced to live with people you don't know or like in order to have a shower, or go to the shops. Imagine that you have to go to bed at 8pm, and go to the toilet at 6am every day, because that's the only way you can have help to do that at all.

The NDIS is intended to de-link disability support from housing and allow people with disability the kind of choices that everyone else takes for granted. Individual people will each have a funding package based on their individual needs. But where does housing fit into this kind of model?

Can't make do with failed responses

CripCroakey: why the 'problem' of housing for people with disability is one for everyone

Disability housing has become a battle ground in New South Wales, outlining many of the challenges that the NDIS is bringing to disability support, and also how the broader problems with housing are even worse for people with disability.

As part of the NDIS Enabling Act 2013 in NSW, all state owned disability housing is to be transferred to the non-government sector, and the remaining large institutions are to be closed.

The NSW Council for Intellectual Disability has put forward **strong recommendations** about what should happen to these group homes and institutions – they call for ensuring that community housing services manage them, not disability service providers. After all, this is what happens with all other types of housing. If one of the goals of the NDIS, and the National Disability Strategy, is to ensure that people with disability have the same access to services as everyone else, then surely their housing has to change too.

The problems for people with disability in getting access to housing are in part the same problems as other low income groups. Housing **affordability is a massive issue** in Australia, and needs some serious policy responses. The parts of our cities that have job growth and public services shouldn't only be available for the rich. If the reform of the disability sector is going to be real, then people with disability must be able to be a part of the whole of our society, not shunted off to that corner over there.

People with disability don't need 'special' housing; they need the same kind of housing as everyone else. The lack of affordable housing is perhaps a chance for disability and housing groups to work together, to create coalitions, to push for change that will truly realise the vision of people with disability being included and part of the community.

HOUSING GOALS FOR THE FUTURE

Think about where you live – how many disabled people do you see in your street, suburb and neighbourhood? At the shops, pool or on the train? People with disability deserve to live in the community, just like you do. Any housing policy that doesn't end up with this result will be a failure.

[Declarations: I am the co-Vice President of Women with Disabilities Australia and currently working as the Media and Communications Officer for People with Disability Australia. These views are my own and not of these organisations.]
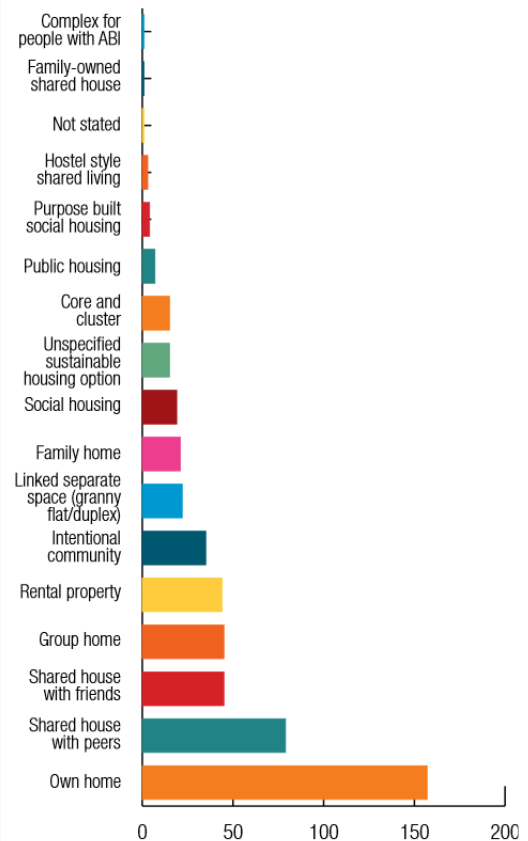
You can track the #cripcroakey series **here**.

Croakey acknowledges and thanks all those who donated to support #cripcroakey

The tables in this post come from A place I can proudly call home: Every Australian Counts campaign – housing stories.

New report illustrates "the collision" of economic, health and social agendas

A **new report** from the Australian Council of Social Service (ACOSS) investigating the increasing inequality of income and wealth is an important resource for those working to improve the community's health, according to public health experts.

"Finally there is recognition that economic, health and social agendas are colliding," write Professor Fran Baum and Professor Sharon Friel in the article below.

> "*It seems to us that one of the best ways to promote health in Australia will be to follow the recommendations of the ACOSS report and reform capital gains tax discounts, negative gearing and superannuation tax concessions.*"

A Nation's Health Divided

Fran Baum and Sharon Friel write:

The release of **the ACOSS report** this week has once again highlighted the existence of widening income and wealth inequities in Australia, the dangers they pose and the ways in which public policy and responsive regulation can intervene to reduce them.

As the report describes, times when Australia had "full employment policies, universal access to public education, a unique system of wage regulation, progressive income taxes, and a well-targeted social security safety net, meant that we were able to place limits on inequality within an open economy with relatively low taxes and public expenditures, and a flexible labour market."

The benefits of Australia's economic growth from the recent mining boom have been shared much more unequally than in the past.

These inequities are a major risk to our collective health. Wilkinson and Pickett (2007) and others have shown that greater levels of inequity are associated with worse health and social outcomes. Other research has shown that countries with equity-focused public policies can achieve high health status despite not being the richest of countries (for example Sri Lanka, Kerala state in India and Costa Rica (Balabanova, McKee & Mills 2011; Baum, 2008).

This body of evidence demonstrates that it isn't how wealthy a country is that determines the health of its population, but rather how the products of its economic growth and national wealth are invested and distributed.

New report illustrates "the collision" of economic, health and social agendas

The benefits of the recent economic boom have flowed largely to individuals rather than being invested for the public good.

Patterns of taxation, employment, housing, social exclusion, education and income are some of the social determinants of health, and combine to affect health inequities. In Australia differences in opportunities in each of these areas mean that Aboriginal and Torres Strait islander people die on average around 11 years earlier than other Australians (AIHW, 2015) and low income people lose about 6 years of life compared to better off Australians (Leigh, 2013). The distribution of power, money and resources shape these opportunities.

Policies in each of these areas, therefore, can have a powerful impact on how long we live and how healthy we are. It has been encouraging to note in the last year that Australians have rejected (with the help of the Senate) policies that were inequitable and which would have made the inequities reported in the ACOSS report more extreme in the future. This is good news for public health and more needs to be done to ensure that inequity is reduced to at least the levels it was at in the 1970s.

Dr Cassandra Goldie, CEO of ACOSS, noted when launching the report that growing inequities in income and wealth are a "problem both socially but also, importantly, economically as the IMF (International Monetary Fund) has alerted us to, with an important report just last week, that if we're serious about economic growth, concentration of income and wealth in the top is bad for the economy".

Finally there is recognition that economic, health and social agendas are colliding.

More knowledge is needed on exactly how we construct public policy to ensure less income and wealth inequities, which will in time convert to health inequities. This is the reason we designed a Centre for Research Excellence on Health Equity to research the ways in which public policies do or do not support health equity. We started from the strong evidence that health equities do not primarily reflect individual behaviour but rather the structures within which people live, work, and play.

It seems to us that one of the best ways to promote health in Australia will be to follow the recommendations of the ACOSS report and reform capital gains tax discounts, negative gearing and superannuation tax concessions.

This will enable more public resources to be available to provide services that address the social determinants of health. Evidence suggests that these are more effectively and efficient provided through universal services that are open to all citizens and which built in special measures to ensure that those facing multiple disadvantage in their lives can benefit from the public services as much as richer people who are able to navigate complex systems.

In order to ensure we are a healthier and more equal nation we need a strong social movement that demands equity from our political leaders and demands that they take account of the evidence that equity is good for our collective health.

ACOSS has presented a strong evidence base in this report, which will enable health groups such as the AMA, the specialist colleges, the Public Health Association and the People's Health Movement to keep advocating and lobbying for equity informed policy and rigorous social and health equity impact assessment on all policy proposals.

New report illustrates "the collision" of economic, health and social agendas

• *Professor Fran Baum, Southgate Institute for Health Society and Equity, Flinders University and NHMRC Centre for Research Excellence, Health Equity.*

• *Professor Sharon Friel, Regulatory Institutions Network, Australian National University and NHMRC Centre for Research Excellence, Health Equity.*

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Housing policies: designed to create stress, inequity and other health and social problems

BY: **Cassandra Goldie & Cath Smith, Sarah Toohey, Adrian Pisarski, Caryn Kakas & Michael Buxton**

The policies of governments at all levels combine to make Australian housing very expensive, and to exacerbate inequities between the housing haves and have nots.

That is one of the overarching themes from the latest **Insight journal**, published jointly by the Victorian Council of Social Service and Australian Council of Social Service on the topic of housing affordability. It has plenty of interesting reading for those with a concern for the broader determinants of health.

Another theme, which also resonates for the health sector, is the difficulty of achieving public interest reforms in the face of powerful interests, whether wealthy homeowners and investors, or developers.

The edition also highlights some of the jurisdictional obstacles to reform. **Adrian Pisarski**, Chairperson of **National Shelter**, writes that "the most alarming element" of the National Affordable Housing Agreement is the hostility between levels of government.

He says: "As one who works in and between both spheres I am constantly surprised at the lack of trust displayed by states and the Commonwealth as they discuss each other's roles. There is a real imperative at the national level to bring the Commonwealth, states, community and private sectors to the table in a spirit of genuine cooperation."

In an article titled "Tale of two cities", **Michael Buxton**, Professor of Environment and Planning at RMIT University in Melbourne, describes the impact of deregulated planning upon urban disparities:

> *Australian cities are increasingly being characterised by two city types as a result of the private sector determining the shape of cities, the type and scale of housing and other uses, the rate of development and ultimately the way cities function. Higher income, tertiary educated, professionally employed households are concentrated in service rich, higher density, inner and middle ring suburbs of Australian capital cities and selected outer urban areas, while lower income households without tertiary qualifications are concentrated primarily in service poor, low density, new outer suburban areas. A range of other public policy measures, such as taxation and incentive programs, have reinforced the disparities in wealth across different areas of cities."*

Meanwhile, thanks to the Insight team for allowing republication of the edition's editorial below, by **Cassandra Goldie**, CEO of ACOSS, and **Cath Smith**, CEO of VCOSS.

At the bottom of their article are snippets from some of the journal articles, but you can **download** the entire edition.

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Housing affordability is a social, economic and health concern

Cassandra Goldie and Cath Smith write:

Housing affordability is one of the most difficult and intractable issues facing Australia as a nation. Not only does it create widespread 'housing stress', where people living on low incomes are forced to pay so much for housing they must skimp on essentials like food and health care, but our obsession with home ownership and housing investment is a permanent drain on economic growth and prosperity. This would be a tragedy if we had no solution. It is even more so that, in fact, the solutions are known, but the political will to change is not yet present. However, this simply invites us to embark on a journey of change.

This journey will necessarily involve a transformation in public understanding – where ordinary Australians learn about what is causing constantly increasing housing prices, both to buy a property and to rent [see the article, 'The Politics of Housing' and Benjamin Law's 'Generation Rental']; and then become angry about government failure to act, including changing Australia's tax settings, which win the dubious honour of delivering more generous tax benefits to housing investors than any other nation in the world, and our First Home Owner's Grants, which deliver scarce tax dollars straight into the bank accounts of housing vendors ['Door should close on the First Home Owner Grant'].

At this point the journey must turn to our political leaders, who will need to exercise keen intelligence and strong political will to turn the housing policy Titanic around. For real and systemic change that will truly deliver a housing system where every person's right to be affordably and decently housed is met, this transformation will need to include:

• reform of funding for affordable housing programs [see the article, 'Shining the spotlight on the National Affordable Housing Agreement', and 'Housing bonds: back on the agenda],

• reform of state housing taxes ['Scrapping stamp duties for a land tax'],

• an overhaul of federal housing tax settings, income support and Commonwealth Rent Assistance [See 'low income + high rental is a poor equation' and 'Fixing rent assistance'],

• smart policies to deliver direct assistance to first home owners that is actually helpful, including scrapping first home owner grants and use of shared equity ['Shared equity: new models at work in WA'], and

• a new approach to planning and urban development ['Tale of two cities: supply and demand' and 'Investing in infrastructure'].

Housing policies: designed to create stress, inequity and other health and social problems

To show the way we can see some beacons of hope in existing policies in some states and territories, most notably: the exciting self-funding home ownership models in Western Australia, the inclusionary zoning successes in South Australia and the ACT ['State of housing in Australia'], and federally in the gains made from the often un-lauded but nonetheless significant accomplishment of the Nation Building stimulus package for public and community housing, the success of the National Rental Affordability Scheme, and the progress in addressing homelessness ['The Road Home: how are we travelling'].

Welcome too are the early insights into views and priorities of the new Federal Housing and Homelessness Minister Brendan O'Connor, outlined here just weeks after his appointment ['In conversation'].

We hope this special national edition of Insight, developed by VCOSS in partnership with ACOSS excites your interest to fight with the COSS network and broader community sector for a fairer Australian housing system.

Visit **here** to catch up on an earlier national edition of the magazine, Fair share, which focused on tax reform, and offered additional analysis about the impact of housing taxation on affordability.

Extracts from other articles

The politics of housing

Sarah Toohey, Campaign Manager of Australians for Affordable Housing writes:

The trouble with housing policy is that housing politics is just so damn hard. What might seem like self-evident solutions will affect the wellbeing (perceived or otherwise) of over eight million Australian households, the vast majority of which are home owners who have, on average, nearly half of their household wealth invested in their home.

When we talk about improving housing affordability, what we mean is slowing down house price growth and, with it, the growth of the investments and wealth of almost seven out of every 10 households. That's a hard sell.

The current tax and transfer system favours home ownership and encourages over-investment in housing. By and large households receive more in tax breaks the older and wealthier they are and the more expensive their house is.

Sadly the national conversation around housing is dominated by investment speak and industry analysts, people whose interest is in making money from housing – and that's the opposite of making housing affordable.

Strangely these industry advocates do proffer a range of solutions to housing affordability that are faithfully reported in the media. Sadly these solutions are more ad hoc than systemic and more self-serving than saving. They advocate for an expansion of our cities, when all evidence suggests that this means low income households get pushed out to areas with few jobs, and little public transport.

Housing policies: designed to create stress, inequity and other health and social problems

National Affordable Housing Agreement: Where to now?

Adrian Pisarski, Chairperson of National Shelter, writes:

The first National Affordable Housing Agreement (NAHA) was disappointing on many counts, not least of which that it cut funding for public and community housing by around $1 billion in comparison to its predecessor, the Commonwealth State Housing Agreement (CSHA)3.

The cuts aside, it was a conceptual breakthrough to move from a funding deal between the Commonwealth and States to a properly national agreement, with roles for the other critical players in housing affordability: local government, the community sector, and private finance.

This breakthrough also meant housing policy and funding issues were elevated from Commonwealth and State Housing Ministers and officials to the more powerful central agencies (Premiers, Treasurers and the Prime Minister).

. . . .

Investing in infrastructure

Caryn Kakas, Executive Director of the Residential Development Council, a national policy division of the Property Council of Australia, writes:

Housing affordability is a puzzle that remains unsolved by all levels of government with Australians continuing to have only limited and unaffordable housing options in both the rental and home purchase markets.

In fact, Australia ranks only behind Hong Kong as being the least affordable housing market in the world, according to the 2012 Demographia International Housing Affordability Survey.

This report found that homes in Australia cost 5.6 times the average salary, compared to the broadly accepted standard for affordability of three times annual income to buy a home.

This means that families without at least two full-time employed members are often priced out of home ownership.

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Tale of two cities

Michael Buxton, Professor of Environment and Planning at RMIT University in Melbourne, writes:

Land use planning is a potentially powerful tool for increasing housing affordability. However, in Australia it remains largely unused for this purpose.

The current deregulated planning systems in fact decrease affordability and increase spatial inequality. Everyone wants improved housing affordability but it remains an orphan.

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Housing policies: designed to create stress, inequity and other health and social problems

Average Australian outer urban house and lot sizes are the world's largest, with little diversity apparent. There is now a major mismatch between average household size (2.6 people per household) and dwelling size (Australian homes now have the largest average floor size in the world, 245.3 square metres in 2008-09, with an average 3.1 bedrooms per dwelling).

Again, because of a failure of government, development companies determine the prevailing pattern of urban design. This conventionally takes the form of large detached houses in single use subdivisions poorly served by public transport, kilometres from retail and other services, and long distances from employment.

This has major implications for housing consumers. Firstly, relatively large, uniform housing and land products cost more to buy. Secondly, the dominant urban form of Australian outer suburbs leads to high social and other costs to residents.

Outer urban household operating costs are rising alarmingly. Home energy costs are significant and will increase substantially. For many people, transport costs in new car-based suburbs are the second highest household operating cost.

Why 100 years without slum housing in Australia is coming to an end

Truth be told, most Australians live in good housing. This is good news for all of us because our housing is a major determinant of our health and wellbeing. But our very recent **research findings**, published this month in the Journal of Prevention and Intervention in the Community, and the lessons of history tell us this good news story is at risk.

Ideally, housing provides us with the secure, comfortable shelter that people and their families need to live healthy, productive lives. In general, we have a modern housing stock with good heating and cooling, few major structural problems and few problems with damp and mould. By contrast, bad housing makes it much more likely you will get sick and stay sick once ill.

In Australia's early years, much of the housing stock was of poor quality, often overcrowded, and posed real risks to people's health. Slums were common in the inner parts of the major cities and in many country towns.

As late as 1915 **bubonic plague was a reality** in the poorer parts of our cities and other contagious diseases remained an ever-present risk. Numerous letters to the editor documented a real social concern with the housing standards of the poor.

Government intervention, economic prosperity and tenancy laws all improved housing conditions across Australia. Within a century Australia was defined by good housing and high rates of home ownership. The nation **saw off the last of its slums** in the late 1940s.

Now the same conditions that gave rise to substandard housing in the 19th century are returning in the 21st, with a likely similar outcome. Recently, the Reserve Bank governor acknowledged young Australians **need their parents' help** to buy a home in Sydney. But most Australians don't have a wealthy and doting parent to fund them into the house of their dreams.

The alternative is to live in lower-quality housing and to make do with a home that is relatively inaccessible, fundamentally unaffordable or both.

A million Australians on the housing brink

The confronting reality is that poor housing conditions are more prevalent in Australia than we think.

We have a sizeable "hidden fraction" of Australians living in poor-quality housing. In particular, many of our most vulnerable have the double disadvantage of also having housing conditions that we might deem as falling below an unacceptable standard.

In one of the few contemporary analyses of this issue, we used the Household Income and Labour Dynamics (**HILDA**) Survey, a national longitudinal dataset, and find compelling evidence of a substantial stock of poor-quality housing in Australia.

The scale of our findings is somewhat surprising: we found almost a million Australians are living in poor or very-poor-quality housing. Within this total, more than 100,000 are residing in dwellings regarded as very poor or derelict.

These simple findings are important. They show the existence of a significant (and currently little known) population of individuals living in very poor conditions. At the very least, we need to monitor Australian housing conditions in a systematic way if we are to avoid this problem worsening.

Harms of poor housing multiply

Poor-quality housing makes the already disadvantaged even worse off. Younger people, people with disabilities and ill health, those with low incomes, those without full-time (or any) employment, Indigenous people and renters are much more likely to be found in the emerging slums of 21st-century Australia.

Importantly, many of these groups are already disadvantaged and (most probably) have a pressing need for housing that improves or supports their health and wellbeing. People with an existing illness or disability, for example, are almost twice as likely to live in dwellings in very poor condition as people without a disability or illness.

These findings about the size and uneven distribution of the problem should force us to ask what effects poor-quality housing has on people – on their mental, physical and general health? It is clear from our analysis that such housing has measurable impacts on mental, physical and general health. This impact is large enough to be statistically significant.

Given the time it takes to reform policy and plan for our cities and regions, Australia urgently needs to face up to the dismal reality that once again many Australians are living in housing not fit for habitation.

Governments must take steps to ensure the supply of affordable housing of reasonable quality. Otherwise, we are destined to become a nation scarred once again by slums, reduced life chances and shortened lives.

Emma Baker is Associate Professor, School of Architecture and Built Environment at the University of Adelaide; Andrew Beer is Dean of Research and Innovation at the University of South Australia; and Rebecca Bentley is Associate Professor in the Centre for Health Equity, Melbourne School of Population and Global Health at the University of Melbourne.

This article was originally published on The Conversation. Read the original article.

Mental health

croakey

For better mental health, advocate for fairer, more inclusive societies

Mental health advocates should be campaigning for more equal, inclusive and stronger communities, according to a provocative and challenging keynote presentation to the **Towards Recovery** conference in Melbourne.

Dr Simon Duffy, founding director of **The Centre for Welfare Reform** in the UK, told the conference that while the welfare state is a good thing, it had been poorly designed, creating an "empire of services" that end up protecting their own interests and undermining the possibility of better solutions.

This had led in the UK to many in the charity sector providing poor representation of the people they were charged with supporting, with fear of losing funding having "killed the independence of leading charities".
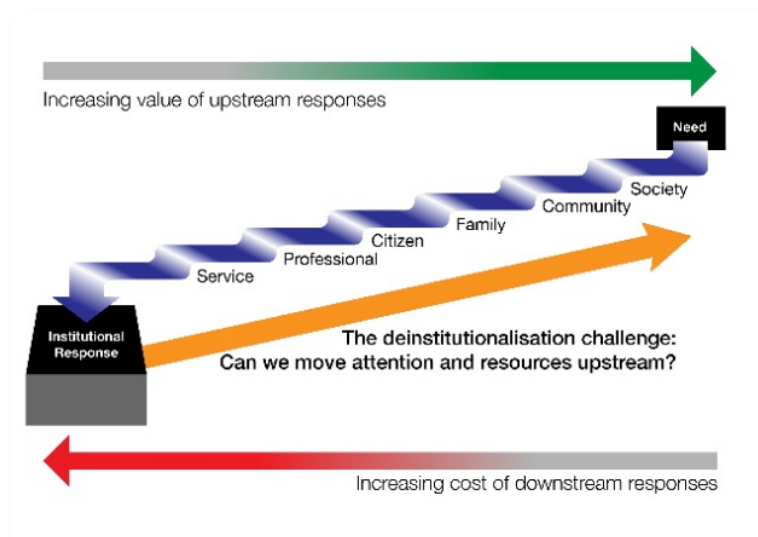
As a result, he said, we are failing to truly address complex issues contributing to poor mental health, and actually causing mental illness.

He cited evidence showing a correlation between inequality and mental illness, that more mental health services don't necessarily mean better mental health, and that mental health improves in strong communities.

If you believe in mental health you should be against high levels of income inequality; campaign around that," he said.

"I do think a lot of organisations, if they're not careful, their main purpose becomes surviving."

The **#TowardsRecovery** conference, is convened by VICSERV, the peak body for community managed mental health services in Victoria.

Other issues being discussed include the challenges of the National Disability Insurance Scheme (NDIS), mental health reforms and the emerging role of Primary Health Networks.

For better mental health, advocate for fairer, more inclusive societies

Duffy cited what he said was much contested but **enduring evidence** of better outcomes for people with schizophrenia in developing nations, possibly because of greater community inclusion, involvement of traditional heating rituals, valued work roles and extended kinship.

And he talked about the harsh impact and culpability of recent UK government policy – "Mrs Thatcher had nothing on these people," he said.

The introduction of "work capability assessments" of people with disability and mental health issues had led over three years to multiple social issues, including increased rates of suicide.

"That's government policy," he said. "Those are the folk we ask to take care of society."

He talked about the need to shift funding, resources and attention "upstream", telling the "parable" of three friends out for a walk

The welfare state's a good thing, but we've **designed** it wrong. We try to solve social problems with money and power and we end up solving the wrong problems in the wrong way. Over time we've created an **empire of services** that protect their own interests and undermine the possibility of better solutions. This is causing mental illness, and many other problems. We need to rethink the system - and more importantly we need to reclaim our own **citizenship**.

by a river, who found a baby had been thrown in, and then another, another, and more babies.

They start saving them, then one began to run off up the river. When the others asked why he wasn't helping, he said: "I'm going up the river to find out who's throwing all these babies in."

Duffy highlighted two groups he had studied that had emerged from local communities with innovative new approaches to tackle their own issues. One was the **People Focused Group Doncaster**: peers with mental health problems who came together on a project and got more out of working together than from the project proper.

The other was an example of an innovation alternative, the West Yorkshire-based **WomenCentre** that has delivered significant improvements in health, justice and safety issues for very vulnerable women and families who had, he said, effectively been deemed too complex by other services.

He showed a slide documenting what "label" was given to women in the centre when they arrived, versus other very pressing issues they faced ("they come in with a mental health issue but really the pressing problem was, say, debt or dentistry") and then what was their real underlying problem. Read **his report** on its work.

Duffy has worked for many years in self-directed care. His mantra is that it is not choice that is vital, but control over their own lives. He said Australia had lagged in the area in the past, but was now taking it on in a very exciting but risky way, through the NDIS and consumer-directed care in aged services.

"You've created a whole new bureaucracy to do it, one big experiment all at the same time using some very elaborate technology," he said.

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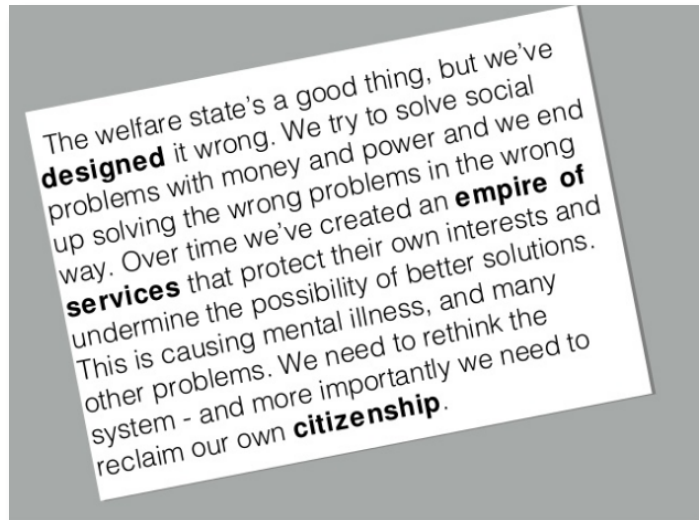
"I hope it works because it's the most exciting thing happening internationally, but I've never seen anything quite like this so I'm worried and when I come to Australia I see a lot of worried faces". The risk, he said was it could become an "expensive mess".

For better mental health, advocate for fairer, more inclusive societies

Service label	n	Urgent problem	n	Real need	n
Victim of domestic violence	55	Debt	50	Better self-esteem	64
Mentally ill	39	Housing	48	To overcome past trauma	54
Criminal	35	Benefits	46	To manage current trauma	51
Poor mother	33	Health	37	To stop being bullied	50
Misuses alcohol	24	Rent	32	Guidance	50
Uses drugs	22	Criminal justice Advocate	24	Relationship skills	45
Violent	19	Dentistry	8	Mothering skills	26
Chronic health condition	16	Others	3	Others	1

And he warned that his critiques of welfare were no justification of Big Society style polices, where "suddenly the system its so carried away it forgets that some things can't be done through individualised funding…You don't commodify the social worker: some things are infrastructure and need to be treated differently."

Questioning language

Duffy also questioned the use of the term "consumer" in mental health, and challenged the mental health sector to complete the process of de-institutionalisation, which he said had only just started. Community services were, he said, "at a crossroads".

He asked: Are they "just a buttress to the empire, part of the system, not really of community?" Or are they organisations of the community, that grow out of it and nurture it?

The conference chair Lyn Morgain, CEO of cohealth, later told Croakey,that Duffy's presentation was "incredibly thought provoking and challenging".

She said some in the sector would struggle with his opposition to the term "consumer", given the history behind its use here.

"The other (challenge)," she said, "was the risk that what he is suggesting – community engagement and ownership as an alternative to the welfare state – can be readily appropriated by political forces that perhaps don't have the best interests of the community at heart."

She did not believe Duffy was at all naive to that risk: "I think he says that we can't risk not talking about it."

- See Simon Duffy's slideshow **here**.

- And follow him on Twitter at **@simonjduffy**

For better mental health, advocate for fairer, more inclusive societies

Tackling racism: urgent priorities for children in out-of-home care and immigration detention

BY: **Racism and Child and Youth Health symposium participants**

Racism and Child and Youth Health Symposium Statement

This summary and recommendations were developed as part of a one-day symposium on Racism and Child and Youth Health funded by the Lowitja Institute and hosted by the Melbourne School of Population and Global Health, University of Melbourne and the Centre of Citizenship and Globalisation, Deakin University.

More than 100 participants from academic, government, non-government and community sectors, including leaders of Aboriginal and multicultural community groups, across Australia and internationally attended the symposium.

Racism is a prevalent and pervasive issue that harms health and hinders the development and participation of children and young people in Australia throughout their life stages. Children and young people need skills and support to achieve optimal health and development in the increasingly multicultural world in which we all live.

There are multiple forms of racism that affect children in the Australian context. These include intentional and unintentional behaviours, biases, beliefs, assumptions, and stereotypes. These can occur within systems and institutions of society, as well as via interpersonal and internalised racism. All of these forms of racism require carefully considered, evidence-based solutions.

There is limited evidence in Australia to help us to understand the extent to which the multiple forms of racism are experienced by children and young people, and the forms of racism experienced across racial and ethnic groups. Greater understanding of diverse experiences of racism, and their impacts on children and young people, requires systems in which children and young people can voice their own experiences and offer up the means to collect, curate, educate, disseminate and archive those experiences for understanding and action.

Racism is a key determinant of mental and physical health and wellbeing, and thus should be prioritised in child and youth health policy and discussions. This includes identifying and addressing the impacts of racism on children and young in other national initiatives and inquiries such as those focused on suicidal behaviour and self-harm, bullying, and access to mental health prevention and care services. Evidence-based solutions must be a priority in offering greater support to children and young people experiencing racism and its harms.

Tackling racism: urgent priorities for children in out-of-home care and immigration detention

Education to combat racism should start in early childhood, have a whole of community focus and should continue across each stage of life. Behavioural change programs need to cross all sectors of the community and be visible to a wide audience.

Positive work within a number of existing programs that aim to address and prevent racism and its adverse affects for children and young people is acknowledged. Programs need to be grounded in evidence and respond to common experiences of racism, but also nuanced for specific racial/ethnic groups and contexts.

Anti-racism campaigns should focus on creating sustainable attitudinal and behavioural change and subsequently must be implemented over time rather than as one-off events. Research documents that ill-conceived anti-racism campaigns can do more harm than good, further reinforcing the need for evidence based approaches that are regularly monitored and evaluated.

Historic and political forms of racism impact on particular racial/ethnic groups, at different times and for different reasons. The symposium identified that children in immigration detention and Aboriginal children in out-of-home care were two groups requiring urgent and targeted attention. It was clearly stated that wherever possible, children should be supported to remain with their families and in family based settings.   Settings that institutionalise family life have clear and serious impacts on children's mental, physical and emotional health.   Child protection systems must consider cultural identity and connection to culture as an important factor in the picture of children's health, safety and development.

Recommendations:

Participants in the 'Racism and Child and Youth Health Symposium' called to attention the critical need to

- **invest in systematic, quality, data collection reflecting the multiple ways in which racism can operate and be expressed, and impact on the lives of children and young people across different population groups, settings and contexts. This must include good quality data collection of children and young people's racial/ethnic background and identity, within national representative population data.**

- **deliver evidence-based solutions offering support to children and young people who experience racism within programs focused on suicidal behaviour and self-harm, bullying, and access to mental health care services, as well as via initiatives specifically targeting racism. This may include peer-support programs; multicultural programs; and training in schools promoting resilience and coping, as well as anti-racism and prejudice prevention initiatives.**

- **identify the audiences and placement for education and behaviour-change programs combating racism, with particular focus on introducing anti-racism programs in early childhood.**

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Policy responses

croakey

If Australia took any notice of the Marmot Review…

Following on from previous posts about the **Marmot Review**, below is a piece I wrote for the Crikey bulletin, which asks: Why is Australia dragging the chain on health inequalities?

I hope it prompts a rash of health equity advocates to come out of the closet and engage with Croakey, and public debate more broadly!

If Australian policy makers acted on a landmark report aimed at tackling inequalities in health that was released in the UK yesterday, this is what would happen:

- Federal, state and local governments would evaluate all policies and programs (not only the health ones) according to whether they increase or reduce health inequalities

- Paid parental leave would be available for the first year after baby's arrival, and flexible employment arrangements thereafter

- Good quality childcare would be available and affordable for all, including for some parents who are not working

- Efforts to improve education outcomes would focus less on schools, and more on supporting parents and communities to help children's development

- There would be a major shake-up of health spending in favour of early childhood support and development programs, and public and preventive health generally

- Economic growth would not be the most important measure of our country's success, and the fair distribution of health, well-being and sustainability would be important social goals.

The report, *Fairer Society, Healthy Lives*, sets out the rationale, evidence base and strategies for tackling health inequalities, and was commissioned by the British Government in response to the 2008 report of the WHO's Commission on the Social Determinants of Health.

It is also known as the Marmot Review, as it was produced by a group chaired by Professor Sir Michael Marmot, who also chaired the WHO's Commission.

The report argues that reducing health inequalities is a matter of fairness and social justice, with many people dying prematurely because of societal inequalities that contribute to poor health and earlier deaths.

As well, it says that reducing health inequalities will have economic benefits in reducing losses from illness associated with health inequalities, which contribute to productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

If Australia took any notice of the Marmot Review…

It's interesting that the debate about health equity has advanced so far in England, with high-level government endorsement for the report. It's also worth noting that this is England's **second major review** into inequalities.

In Australia, by contrast, concerns about health inequalities are barely evident in our health reform discussions, which tend to remain focused on professional turf wars, hospitals, and surgery waiting lists. Behind the scenes, we may be doing **some good work** but you'd never know it from the headlines.

I've been wondering about this lately, why is the country that has historically prided itself on "the fair go" so unenthused about the fact that children born in one suburb are so much more likely to suffer poor health and to die younger than children born in a wealthier suburb?

Should we blame the media for our lack of concern? This **recent study** found that Canadian media outlets don't have much time for stories about health inequalities, and I'd be surprised if things were any different here. Perhaps journalists could be asking questions about health equity much more than they do, and not only of health ministers. The American Association of Health Care Journalists has gone so far as highlighting ways its members can make stories about health inequalities interesting to a broader audience.

Should we blame academia? Australia suffers from a dearth of active public advocates for health equity. We have some international leaders in the field, such as **Professor Fran Baum**, but more could be done to develop our capacity. The Marmot review also identified the "modest" evidence base relevant to public health interventions to reduce health inequalities. In 2005 it was estimated that of the research published on public health, only 0.5% of articles were related to interventions, with most research describing inequalities rather than providing evidence on how to reduce them.

Should we blame professional organisations? These are motivated by the interests of members, who've traditionally gravitated to well-heeled areas of practice, whether the leafy suburbs or procedural medicine. I was stunned to learn recently that Marmot will soon take over as president of the British Medical Association. Somehow, I just can't imagine a Marmot-style figure at the helm of the AMA, can you? But what a difference it could make.

Should we blame politicians? Tackling health inequalities requires strong leadership, the Marmot Review notes. Health ministers are meeting today, and a health equity expert at the University of NSW, Ben Harris-Roxas, would like to see them consider setting targets for reducing health inequalities. "A high profile inter-governmental review might help them," **he wrote at Croakey**.

But politicians tend to take their lead from the public and opinion polls.

So it comes back to us. It will be interesting to see how much, if at all, Australia engages with this report. It hasn't made much of a dent in the headlines, yet. It deserves to.

Why we need an Australian Health and Equity Commission

England has had the **Marmot Review**, which was commissioned to help shape a policy response to the landmark 2008 report from the WHO's **Commission on the Social Determinants of Health** (CSDH).

Australia, so far as Croakey knows, has shown no such initiative. Why? And what could we be doing to help redress health inequities?

These are some of the questions that have been addressed below by Professor Fran Baum, professor of public health from Flinders University, who was one of the Commissioners on the CSDH.

Fran Baum writes:

"I spent three years (2005-08) working closely with Professor Sir Michael Marmot when I was a Commissioner on the Commission on the Social Determinants of Health which he chaired. I wasn't surprised then to read his hard hitting review *Fairer Society, Healthy Lives* (also known as the Marmot Review) which makes the point forcefully that if we want a healthier and more equitable society then we have to focus society's attention on the underlying causes of ill-health and act on the social and economic determinants of health.

If the Marmot Review's recommendations are implemented in the UK, then there will be greater investment in education, especially for young children, urban planning that supports healthy lifestyles and is kind to the environment, experimentation with models of local governance, re-engineering of work so that it is supportive of good heath, more progressive taxation and new forms of national accounting that measure how happy and satisfied people are and the extent to which a nation's way of life is sustainable. The Marmot Review also notes that the evidence is accumulating to show that societies that distribute their resources more equally tend to be healthier.

The Marmot Review has taken the recommendations of the international Commission on the Social Determinants of Health's report *Closing the Gap in a Generation: Health Equity through action on the social determinants of health*, and applied them to the UK and provided a vision of how the UK can be healthier.

I had a mixed response to reading the Marmot Review. On the one hand I was glad to see how our Commission's report translated to a developed country context and very much enjoyed the depth of evidence and support for an approach to health that tackles the underlying determinants.

Another part of me felt a sharp pang of regret that no Australian equivalent of the Marmot Review has been commissioned by the current Government and that I had failed in my mission to ensure that the CSDH's report was acted on by Australia.

Why we need an Australian Health and Equity Commission

Since the CSDH report, there has been no shortage of reviews of the health system. The trouble is that these have really been reviews of the illness system and none of their reports have offered a progressive alternative to business as usual in the health sector but rather suggested some tinkering with the way we currently organize health services in response to illness.

Thus the National Health and Hospital Reform Commission final report "*A Healthier Future for All Australians*" just considered reform within hospitals and primary health care and while it contained the odd mention of social determinants of health, did nothing to lay out a comprehensive plan of action for tackling them.

More disappointingly the National Preventative Health Taskforce had terms of reference that focused on tobacco, obesity and alcohol and forced the attention of the Taskforce to mainly downstream factors that contribute to the epidemic of chronic disease. Most of its recommendations relate directly to changing lifestyles and pay only limited attention to changing the underlying social and economic factors that account for people's unhealthy food, exercise, smoking and alcohol habits.

By contrast, the Marmot Review really went way beyond the tip of the iceberg and showed that the way we plan our cities, market food and alcohol and design our transport systems all are complicit in unhealthy lifestyles.

Thus in Australia when we have turned our attention to "health" what we have really meant is illness and how we cope with it. This is of course important but it leave open the question of how to we promote positive health and well-being and ensure that it extends throughout our community far more fairly than at present.

There is one area where I think the Australian government's response may hold more promise and that is the COAG commitment to closing the health gap between Indigenous and non-Indigenous Australians which is currently about 17 years of life expectancy. This initiative is attracting significant funding and there is some evidence that the social determinants of health including housing, employment and education are being addressed.

The one glaring gap here from the CSDH's and Marmot Review agenda is that the various interventions (including the notorious Northern Territory Intervention) are not heeding the strong evidence that improvement in health and well-being is generally dependent on forms of intervention that increase peoples' control and result in them feeling empowered. Compulsory quarantining of welfare payments does not fit this bill and if the Nobel-prize winning economist Amartya Sen among others, is correct, having control and power to decide your own destiny are essential to development efforts.

Aside from an Australian Government finally paying serious attention to improving Indigenous health, we need to ponder why successive Australians governments have paid so little attention to health inequities and certainly a lot less than Europe does. The data are clear and show that economically better off Australians do better than their less well-off counterparts in terms of life expectancy, rates of most diseases and behaviours that affect health. The differences are systematic and the evidence is stacking up to suggest it is the underlying causes that create these systematic differences.

Why we need an Australian Health and Equity Commission

I think two reasons account for this. The first is that Australians still like to hang on to the idea that we are a classless society or certainly one where class counts less than in Europe. Acknowledging health inequities requires acknowledging class and entrenched privilege.

Secondly, I think there is a strong vein of individualism running through the policy discourses of both major parties. By this I mean that explanations of inequity tend towards looking at the personal lifestyles and habits of the groups that suffer the worse health and finding that they are to blame for their health status. There are examples of from both the last two health ministers' (Tony Abbott and Nicola Roxan) speeches that they easily revert to this position and see that chronic disease could be reduced if only people would eat the right food or exercise enough.

It is rare for an Australian health minister to give a speech that shows a sophisticated understanding of the underlying determinants of health and health inequities.

We are now in an election year and I would love one of the major parties to develop a platform based on tackling the underlying causes of ill-health and health inequities.

This would require real acknowledgement of the inequalities that exist both between Indigenous and non-Indigenous Australians and also between Australians of different socio-economic classes.

You are much more likely to live longer if you are born to a better off family and you receive better education and then occupy a white collar job. As the Marmot Review points out some societies do much better in terms of distribution of health than Australia does and there would be much to learn from international comparisons. Progressive social and economic policies can do much to reduce the gradient in health.

If I was advising the current Federal Government I would recommend that we establish a Standing Commission (much like the Australian Competition and Consumer Commission – the ACCC) with a brief to work across government to establish and monitor mechanisms to encourage action in all government departments on the determinants of overall population health and to reduce inequities.

This Commission would have a specific brief to look beyond behavioral explanations of health inequities and consider the underlying factors that perpetuate inequity. This Commission (let's call it the Australian Health and Equity Commission) could build on the work of the CSDH, the UK Marmot Review and the work of the European Union on its Health in All Policies program. This latter program is being implemented by the South Australian Government and is demonstrating that with careful implementation health can be promoted by in all areas of government including urban planning, digital technology, water provision and education.

The Australian Health and Equity Commission would develop health and equity impact assessments to consider a range of government policies. This Commission would also work with the existing Social Inclusion Board to determine its role in reducing health inequities. The Commission would also be tasked with selecting and choosing new measures by which to judge our progress as a society – measures that are directly concerned with health, happiness, well-being and sustainability.

My other advice to the Federal Government would be to establish local healthy and sustainable community projects to link State Government departments and local government in dynamic partnerships that would involve citizens in how to plan and develop local areas in a way that promotes health, equity and sustainability. The World Health Organisation's Healthy Cities program provides an ideal model that could be expanded to include consideration of environmental sustainability.

Why we need an Australian Health and Equity Commission

What the CSDH report and the Marmot Review do so well is to knock on the head any simplistic idea that our health status reflects our individual determination to be healthy. They both show that health and its distribution are the result of how we organize our political, economic and society affairs.

One of the crucial raison d'etre of having a democratic government is to organize those affairs so that all Australians can enjoy the best possible health and lifestyle in as fair a manner as possible.

So when will we see an Australian response to the increasing evidence on the power of social determinants to shape our health and well-being?"

• *Fran Baum is Director of the Southgate Institute of Health, Society and Equity at Flinders University*

Bringing urban design into the health debate

Below is an edited extract from a new book from Catholic Health Australia, *Determining the Future: A Fair Go and Health for All*, which outlines how the recommendations of a 2008 report of the **WHO Commission on Social Determinants of Health** should be adopted in Australia.

. . . .

Poor urban design is a health hazard

Peter Sainsbury, Elizabeth Harris, and Marilyn Wise write:

Most discussions about the social determinants of health focus on issues such as income, wealth, social class (a British favourite), socioeconomic position, education, culture, gender, age and race (a favourite in the USA).

In this chapter we focus attention on a determinant of health that is frequently forgotten in discussions about the social determinants of health—the built environment.

But the built environment is not simply another social determinant of health … the built environment is a strong influence on other determinants of health (for instance housing conditions and access to work and educational opportunities), reflects existing social inequalities and hierarchies, and potentially entrenches these inequalities and hierarchies for years to come.

Planning the city

Built environments do not occur only in cities of course—they are created in towns and rural areas, along coastal zones and highways. But globally, and in Australia especially, most of the population lives in cities and this trend is increasing. It is crucial, therefore, that we build cities that promote healthy behaviours and minimise threats to health.

Although there were many positive outcomes associated with better housing and improved neighbourhood amenities in the 20th century, the styles of urban development that appeared in the second half of the century in high income countries often had unintended harmful consequences for community health. The urban sprawl and separation of residential areas from employment zones and shopping and service areas that were features of many cities has been harmful for health in many ways.

The development of far flung residential suburbs, almost always without adequate public transport services, would have been impossible without the increase in car ownership but the people who live in them are totally dependent on their cars—for getting to school, work, shops, recreational facilities and public transport hubs. This had led to decreased physical activity as a normal part of day to day life and contributed to the increasing prevalence of chronic diseases such as obesity, diabetes and heart disease.

It has also reduced the opportunities available for social interaction (an important influence on physical and mental health) through, for instance, increasing commute times, isolating anyone left at home during the day without a car, and separating families from relatives and friends in distant suburbs. The increased dependency on private cars has also increased air pollution and greenhouse gasses, not to mention created the unproductive and unhealthy road congestion experienced in most large cities.

Rapidly developing countries like China have the opportunity as they create many entirely new cities to avoid the mistakes made in developed counties over the last century. Australia, however, will have to remodel the cities we already have.

Building healthy, safe, liveable neighbourhoods

What creates a neighbourhood that is nice to live in, that people want to live in, that helps people to be healthy?

The people themselves are important of course, but having nice, well-meaning individuals is not enough. The local built environment also influences whether people are able to live physically, psychologically and socially healthy lives.

To give just a few examples:

- There was a vogue in the 1960s and 1970s to abandon grid patterns for streets and build suburbs with sinuous crescents and many cul-de-sacs. The idea was to create quiet, private streets that had no dangerous through-traffic and where children could play safely. Unfortunately, the outcomes often were physically and socially disconnected streets, little shared sense of community and long indirect routes from home to nearby (as the crow flies) common destinations such as shops, schools and bus routes. As a consequence, residents used cars for relatively short journeys and the resulting absence of people and interest on the streets further discouraged incidental walking and socialising.

- During the 20th century cars, both moving and parked, progressively displaced people on foot and bicycle from the streets, a domain where before 1900 pedestrians (and animals) had been supreme. The situation became so ridiculous in the later decades of the 20th century that some new suburbs had streets without any pavements, or at best on one side of the street only. For the fit and healthy, walking and cycling became difficult; for people with disabilities and people pushing prams the situation was nigh impossible.

Creating healthy built environments

We know that not all built environments produce good health. We also know that the same built form can have very different impacts in different places, for example … the public housing high-rise estates in inner Sydney and many parts of Europe and the USA often created ghettos of disadvantage, while high rise buildings on the foreshores of Sydney and adjacent to Central Park, New York, are highly desirable and people living there have some of the best health outcomes.

This emphasises the complex inter-relationship between the built environment, the people who live there, the relationships that develop within the community and the extent to which government, the private sector and civil society invest in the 'soft infrastructure' that makes communities work (eg community centres and services, policing and crisis services).

Bringing urban design into the health debate

The good news about the built environment as a social determinant of health is that it is possible for concerned citizens to have an influence on the planning and design of their own neighbourhood, town and city. In small but potentially important ways, individuals can also influence their own and other people's health through the design and appearance of their own homes. And the health and education sectors can play a significant direct role by ensuring that their own hospitals, health centres and schools make healthy, sustainable contributions to the built environment.

There is now a large body of evidence that indicates that various elements of the built environment influence people's health and it is incumbent on everyone who wants to help create healthier built environments to ensure that this is brought to the attention of developers, architects, urban planners, engineers and decision makers, many of whom, it should be said, are already knowledgeable and sympathetic.

We may not have all the answers but ignorance of the influence of the built environment on health is no longer an excuse for fundamentally poor urban design.

• *The authors are from the University of Sydney, and the Centre for Health Equity Training, Research and Evaluation (UNSW). Copies of the book can be ordered at* here.

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Communications issues

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Some suggestions for improving wider understanding of the work of population health

PUBLISHED: **April 10, 2012**

BY: **Ben Harris-Roxas**

How can a wider audience be engaged in the broad-ranging and often complex issues of population health? **Ben Harris-Roxas**, a health impact assessment consultant, has some suggestions in the article below.

And at the bottom of his piece are some details of a new publication and a course for those with an interest in improving the health and wellbeing of locationally disadvantaged communities.

....

Some suggestions for engaging a wider audience in the work of population health

Ben Harris-Roxas writes:

If you follow health reporting on TV or in newspapers you could be forgiven for thinking that the only things that happen are scandals in clinical services or trials of new drugs.

But journalists and PR people aren't necessarily all to blame. As health professionals we often do a pretty bad job at explaining what we're doing.

I've been thinking about how we can do a better job of explaining the slightly more complex interventions that are required for a lot of the population health problems we face. New drugs and clinical stuff-ups fit into well understood **tropes**. We don't have to explain everything, the audience can take shortcuts because they understand what type of story it is.

When it comes to population health issues it's often not as easy because the issues are interdependent, and many of the interventions are unfamiliar to a mainstream audience.

A lot of my work is on health impact assessment, which involves developing evidence-informed recommendations to inform decision-making and implementation. When it's explained like that, it's no wonder journalists aren't interested. It sounds like a technocratic snooze-fest.

Instead, let's think about the demand for new housing in most Australian cities and the pressures to release new land on the fringe. Also think about how disastrous the design of some new suburbs has been for population health in the past by promoting car dependence, limiting walkability and increasing social isolation. The design of our suburbs matters.

Health impact assessment has been a practical way to get people to think about the health consequences of the way suburbs are designed and here's a few examples…

Contrast that story with the bland description of health impact assessment in the earlier paragraph. It sounds a lot more engaging.

We often fail to describe this broader story in population health, not just when pitching stories but also when we communicate with other sectors (or even within the health sector).

Some suggestions for improving wider understanding of the work of population health

Here are four ways I think we could get better at messaging.

1. Don't explain the solution, explain the problem

Or better yet, explain the causes of the problem. **This piece** from the Atlantic Cities is a good example. It describes the phenomenon of "ghost estates" in Ireland, which came about when 2,800 housing developments were abandoned as a result of the GFC. A community group has started planting trees on these sites to reintroduce some aspects of nature into these abandoned building sites. The piece works because rather than leaping into a description of the **NAMA to Nature group**, it first describes the problem as well as its causes. Too often we forget the broader context when describing what we're doing in population health.

2. Don't rely on the usual suspects

There's evidence that people are more willing to listen to arguments when they come from unexpected sources, at argued in this **Ramp Up post**. A good example recently is the conservative economist Judith Sloane's **calls for an increase in the NewStart allowance**. She could hardly be described as a usual suspect when discussing the rights of the unemployed. Different people paid attention to her comments as a result.

3. Avoid jargon and language that alienates people

The importance of this is emphasised in the Robert Wood Johnson Foundation report **A New Way to Talk About the Social Determinants of Health**. People switch off when things are described in stereotypical or politicised terms. As health professionals we often tend to fixate on the solutions and the jargon that surround them, partly because it's what occupies most of our time but also because we are already convinced about the importance of the problem.

4. Describe the human impact

This is often the hardest part for population health stories. Individual stories can illustrate broader population issues but they can also be misleading and seem glib. We often understandably resist this because we have an obligation to respect the dignity and privacy of the people we work with and we can't control how their experiences will be reported. Without the human dimension though it's difficult for not only journalists but also the audience to connect with the story. Human-scale narratives still matter, even with the most abstract ideas.

A good example of a media piece that embraces history, messiness, complexity and a population approach is Melissa Sweet's **description of Miller for Inside Story**. It's a story about the problems faced by a suburb in South West Sydney.

It's an almost impossible story to convey in usual journalistic form because it has a lot of history and people involved and doesn't have a neat narrative arc or resolution. Despite this, the piece manages to convey a lot of the complexity to the reader and provides a number of insights. The point is that it is still possible to tell even the most complicated stories in engaging ways.

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We're confronting big social and population health challenges but we have some ideas about the solutions. We just need to make sure we don't bury the lede.

Some suggestions for improving wider understanding of the work of population health

• *Ben Harris-Roxas is a health impact assessment consultant from Sydney and Health Section Co-Chair of the International Association for Impact Assessment. You can find him on Twitter* **@ben_hr**

Working to improve health in disadvantaged communities

Further to Ben's mention of the **Understanding Miller** story, the Centre for Health Equity Training Research and Evaluation (CHETRE) recently launched a booklet telling the stories of the first eight projects that were part of its courses on working in locationally disadvantaged communities.

The booklet, "Real world stories: reflections on working in locationally disadvantaged communities", describes initiatives ranging from church-based health promotion for Pacific communities, to a project to improve health and educational outcomes for children in Airds and Bradbury, to a coffee club aiming to overcome social isolation in the Ashcroft area, to efforts to boost physical activity among Assyrian, Vietnamese and Cambodian communities, and a nitbusting project at a school where attendance was being affected by repeated infestations.

The booklet doesn't shy away from the difficulties that can arise, telling of the frustrations of delays with ethics approvals, and the difficulties of working with limited resources and of juggling community expectations.

Some of the comments from those involved with the projects included:

...to keep working with people rather than imposing something on them."

We learnt about the important role that health and education play in disadvantaged communities and that health is not just a clinical presence. We became aware of the need to rethink the way we work in order to work within a social determinants model."

This project grappled with a common issue for many health workers – the difficulty of recruiting to a project based around doing something that feels difficult – while recognising that people in disadvantaged communities often have other more pressing priorities than health."

CHETRE is now recruiting participants for its third course. Joan Silk, who edited the new booklet, says: "The course is an outcome of a research program that identified the skills needed to work in or with disadvantaged communities. Project teams in this course are trained and supported to learn more about effective strategies in addressing health disadvantage. The program comprises

workshops, specialist mentoring, site visits and 12-month help desk support from the CHETRE project team. Participants plan, implement and evaluate projects based in disadvantaged communities."

Some suggestions for improving wider understanding of the work of population health

Why I've given up on the mainstream media: public health expert

Dennis Raphael is Professor of Health Policy and Management at York University, Toronto, and co-author of a new report about the social determinants of health, which recently **featured** on Croakey.

In subsequent email conversations, he mentioned his frustration about the difficulties of attracting media interest to such issues. For better or worse, as we all know, if an issue's not prominent in the headlines, it's unlikely to be high on government agendas.

So Croakey asked if he'd write a piece exploring the reasons behind what he calls the "media blackout".

. . . .

Dennis Raphael writes:

While Canada is seen as a world leader in developing health promotion and population health concepts that consider how living conditions shape health, the reality is that Canada has always been a laggard in applying these concepts in the development of public policy. Much of this has to do with the Canadian public's profound lack of awareness which has been abetted by the media's utter unwillingness to address these issues.

For 15 years I have been attempting to have the media in Canada address the broader — or social — determinants of health. My success can be counted on one hand in that a few columnists – not health reporters – have profiled my work on the impact of living conditions and poverty on health.

It was therefore both reassuring – and disturbing – to find that my perceptions of mainstream media coverage were accurate.

Simon Fraser University Health Sciences Professor Michael Hayes and colleagues carried out an extensive analysis of media stories in major Canadian newspapers over an eight year period.[i] Their results were disheartening.

Their analysis of 4732 newspaper articles concerned with health topics found a virtual black-out of stories concerned with the social determinants of health. Only 282 – 6% – newspaper stories were concerned with the socioeconomic environment. More specifically, a total of nine stories (2/10 of one percent) were concerned with how income – the primary social determinant of health – is related to health! There is no reason to think that radio and television coverage is any different.

In a follow-up study, Concordia University communications Professor Michael Gasher and colleagues interviewed twelve Canadian newspaper health reporters about how they went about reporting health stories.[ii]

The barriers to reporting on the social determinants of health as identified by the reporters included: a) lack of knowledge of the social determinants on their part; b) difficulty putting the social determinants into the immediate and concrete "storytelling" that comprises typical news reporting; c) a perception that the social determinants were not new and therefore not newsworthy; and d) concern about "stigmatizing the poor."

Why I've given up on the mainstream media: public health expert

That is the "rational" argument put forth by researchers for this media blackout. I offer a path dependency argument.

First, reporters are regular people. Why would we expect that their understandings of the determinants of health – focused on diet, exercise, and tobacco use — would be any different from the general public? For every one Dennis Raphael trying to communicate findings about the social determinants of health, there are at least 150 Mr and Ms fruit and vegetables researchers bombarding them with their stories.

Second, what are the implications for reporters – and their editors and publishers — suddenly pointing out that their last 1000 stories about fruits and vegetables, exercise, and tobacco use as the primary determinants of health were misguided at best and patently wrong at worst. Witness how the media maintains its saturated fat and heart disease fixation in spite of a decade of research disconfirming the link. Ditto for promulgating the fictions concerning PSA tests, weight, and cholesterol.

Third, reporters work for corporations who benefit from having the social determinants of health story kept secret. Most media – including newspapers – are now owned by large corporate entities whose ideologies and values are not consistent with a social determinants of health perspective. Reporters would probably be well aware of this and like most other salaried workers would hesitate to put their futures on the line by consistently presenting a social determinants of health perspective in their stories.

Fourth, newspapers in Canada have huge "Food" and "Living Sections" that generate significant reader interest and advertising dollars in maintain the fiction that life style choices will help readers live long and healthy lives.

I have given up on the mainstream media. I have no illusions that any message I may wish to communicate will be facilitated by it. Even if the odd story makes it into print, it then becomes lost in a continuing barrage of "healthy living" stories.

Set up your own networks. Use Facebook and Twitter. And besides, nobody between the ages of 16 and 30 watches, reads, or listens to the mainstream media anyway."

[i] Hayes, M., et al. (2007). "Telling Stories: News Media, Health Literacy and Public Policy in Canada." Social Science and Medicine, 54, 445-457.

[ii] Gasher, M., et al. (2007). "Spreading The News: Social Determinants of Health Reportage in Canadian Daily Newspapers." Canadian Journal of Communication, 32(3), 557-574.

Article links

Poverty, inequality and power

Rise & be heard: Joining forces to ask questions, demand answers on poverty – and to be shown some respect – By Linda Tirado
https://croakey.org/rise-up-be-heard-joining-forces-to-ask-questions-demand-answers-on-poverty-and-to-be-shown-some-respect/

International conference puts spotlight on corporate power as a health threat – and calls for Health in All Policies – By Fran Baum
https://croakey.org/international-conference-puts-spotlight-on-corporate-power-as-a-health-threat-and-calls-for-health-in-all-policies/

How inequality creates complex health and policy challenges – By Dr Tim Senior
https://croakey.org/how-inequality-creates-complex-health-and-policy-challenges/

Children's health

How Australia is failing our children – reports from Caring for Country Kids conference
– By Melissa Sweet
https://croakey.org/how-australia-is-failing-our-children-reports-from-caring-for-country-kids-conference/

Putting the spotlight on the first 1000 days, to improve children's futures #LongRead – By Professor Kerry Arabena
https://croakey.org/putting-the-spotlight-on-the-first-1000-days-to-improve-childrens-futures-longread/

Indigenous health

#IndigenousDads: countering racist stereotypes with love & pride – Aboriginal and Torres Strait Islander people on Twitter
https://croakey.org/indigenousdads-countering-racist-stereotypes-with-love-pride/

#CulturalSolutions forum calls for strengths-based, localised approaches to preventing suicide – By Summer May Finlay
https://croakey.org/cultural-solutions-forum-calls-for-strengths-based-localised-approaches-to-preventing-suicide/

"Why aren't I in prison?" … Some questions about white privilege #JustJustice – By Dr Tim Senior
https://croakey.org/why-arent-i-in-prison-some-questions-about-white-privilege-justjustice/

Global health

Planetary Health – the new public health paradigm – By Dr Peter Tait
https://croakey.org/planetary-health-the-new-public-health-paradigm/

Trading away health? The story of a health impact assessment that made a splash – By Fiona Haigh and Katie Hirono
https://croakey.org/trading-away-health-the-story-of-a-health-impact-assessment-that-made-a-splash/

Memo to G20 leaders: the three best buys for health equity (and it takes only five minutes!) – By Professor Fran Baum
https://croakey.org/memo-to-g20-leaders-the-three-best-buys-for-health-equity-and-it-takes-only-five-minutes/

Some big challenges for health promotion (including the "converging crises" of environmental degradation and social injustice) – By Professor Mark Dooris
https://croakey.org/some-big-challenges-for-the-health-promotion-sector-including-the-converging-crises-of-environmental-degradation-and-social-injustice/

A Croakey #longread: remembering those we've lost – and a call to action for planetary health – By Melissa Sweet
https://croakey.org/a-croakey-longread-remembering-those-weve-lost-and-a-call-to-action-for-planetary-health/

In this sometimes dark world….what is the inspiration that we can find for a brighter future? – Siobhan Harpur
https://croakey.org/a-croakey-longread-remembering-those-weve-lost-and-a-call-to-action-for-planetary-health/

Housing

CripCroakey: why the 'problem' of housing for people with disability is one for everyone – By El Gibbs
https://croakey.org/cripcroakey-why-the-problem-of-housing-for-people-with-disability-is-one-for-everyone/

New report illustrates "the collision" of economic, health and social agendas – By Professor Fran Baum and Sharon Friel
https://croakey.org/new-report-illustrates-the-collision-of-economic-health-and-social-agendas/

Housing policies: designed to create stress, inequity and other health and social problems
– BY: Cassandra Goldie & Cath Smith, Sarah Toohey, Adrian Pisarski, Caryn Kakas & Michael Buxton
https://croakey.org/housing-policies-designed-to-create-stress-inequity-and-other-health-and-social-problems/

Why 100 years without slum housing in Australia is coming to an end – BY: Emma Baker, Andrew Beer and Rebecca Bentley – The Conversation
https://croakey.org/why-100-years-without-slum-housing-in-australia-is-coming-to-an-end/

Mental health

For better mental health, advocate for fairer, more inclusive societies – By Marie McInerney
https://croakey.org/for-better-mental-health-advocate-for-fairer-more-inclusive-societies/

#Tacklingracism: urgent priorities for children in out-of-home care and immigration detention – By Symposium participants
https://croakey.org/tacklingracism-urgent-priorities-for-children-in-out-of-home-care-and-immigration-detention/

Policy responses

If Australia took any notice of the Marmot Review… – By Melissa Sweet
https://croakey.org/if-australia-took-any-notice-of-the-marmot-review/

Why we need an Australian Health and Equity Commission – By Fran Baum
https://croakey.org/why-we-need-an-australian-health-and-equity-commission-fran-baum/

Bringing urban design into the health debate – By Peter Sainsbury, Elizabeth Harris, and Marilyn Wise
https://croakey.org/bringing-urban-design-into-the-health-debate/

Communications issues

Some suggestions for improving wider understanding of the work of population health – By Ben Harris-Roxas
https://croakey.org/some-suggestions-for-improving-wider-understanding-of-the-work-of-population-health/

Why I've given up on the mainstream media: public health expert – By Professor Dennis Raphael
https://croakey.org/why-ive-given-up-on-the-mainstream-media-public-health-expert/

Acknowledgements

This publication has been produced by Mitchell Ward, and compiled by Melissa Sweet. We thank all those who have contributed articles to Croakey over the years highlighting the need for action on health inequalities and the social determinants of health and particularly acknowledge those authors whose work features in this publication.

Thanks also to the other members of the Croakey Connective who have contributed to the #MarmotOz festival of the #SDOH: Amy Coopes, Marie McInerney, Dr Tim Senior, Summer May Finlay, Jennifer Doggett, Dr Ruth Armstrong and Dr Megan Williams – as well as all those who have participated on Twitter in sharing news and views.

NOTE: These analytics are from 25 August-noon 30 August, 2016.

The #MarmotOz Influencers

Top 10 by Mentions
- @michaelmarmot 704
- @croakeynews 459
- @croakeyblog 328
- @mariemcinerney 232
- @ben_hr 160
- @jrostant 140
- @nacchoaustralia 135
- @coopesdetat 92
- @aushealthreform 85
- @wepublichealth 83

Top 10 by Tweets
- @croakeyblog 295
- @croakeynews 218
- @mariemcinerney 76
- @jrostant 75
- @malerajustice 59
- @pauldlawton 50
- @fewingsbj 47
- @nacchoaustralia 42
- @ben_hr 35
- @leah_galvin 33

Top 10 by Impressions
- @croakeyblog 4,871,014
- @nacchoaustralia 832,446
- @ben_hr 492,432
- @croakeynews 483,415
- @qanda 319,397
- @timsenior 214,500
- @nrhalliance 211,322
- @wepublichealth 211,233
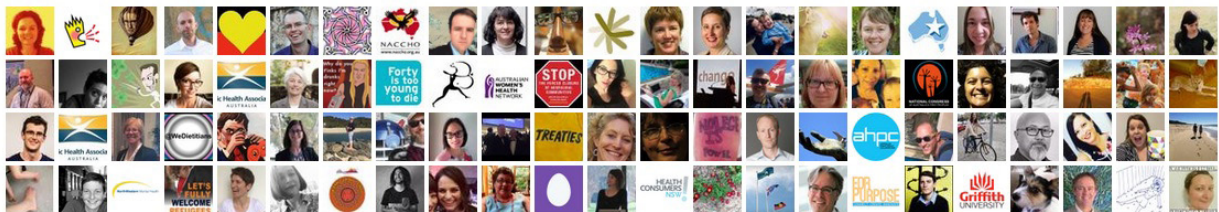- @mariemcinerney 176,753
- @bloomsburysyd 139,299

The Numbers

10,784,842 Impressions
2,713 Tweets
725 Participants
23 Avg Tweets/Hour
4 Avg Tweets/Participant
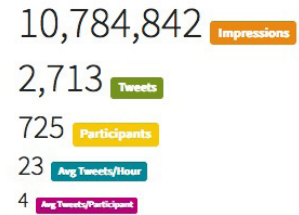
#MarmotOz analytics for time period 08/25/2016 00:00 to 08/30/2016 00:00 (Pacific Time: GMT-0700) [change time period]

#MarmotOz Participants

Supporting Croakey

You can also help to support Croakey by buying some of **our merchandise**.

Professor Sir Michael Marmot and Dr Tim Senior wearing his SDOH! inspired Croakey T-shirt.

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If you are interested in reporting on issues related to the social determinants of health, please consider applying to guest tweet for the rotated Twitter account, **@WePublicHealth**.