Social determinants of health and the Sustainable Health Review

Prepared by WACOSS to inform the assessment of social determinants of health in the implementation of the Sustainable Health Review recommendations, October 2021

Introduction: A vision for Health Equity in Western Australia

A healthy Western Australia: where everyone has a safe home, access to affordable and nutritious food, and the opportunity to pursue purpose and connection through education, work, culture, physical activity and meaningful relationships. This vision is built on a range of social and economic resources needed to ensure equity in health and wellbeing for all Western Australians. Health equity is defined as "the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation)."[1] Health equity requires an expanded vision in healthcare to go beyond the immediate biomedical causes of disease and illness, and towards the "causes of the causes" that account for the vast majority of health inequalities among different groups.

These "causes of causes" are formally referred to as social determinants of health. Social determinants of health – social factors ranging from income inequality to social isolation to discriminatory attitudes and practices - act as powerful countervailing forces against even a well-functioning healthcare system and medical best practice. Research demonstrates that social determinants can be more important than lifestyle choices or healthcare systems in influencing health, accounting for up to 30-55 per cent of health outcomes.[2]

According to the World Health Organisation (WHO), social inequalities and disadvantage are the main reason for avoidable and unjust differences in health outcomes and life expectancy across groups in society. Action, therefore, "requires not only equitable access to healthcare but also means working outside the healthcare system to address broader social well-being and development."[3] The Sustainable Health Review Final Report restates this view in its foreword:

> *Only 16 per cent of a person's overall health and wellbeing relates to clinical care and the role of health ministers and leaders is increasingly requiring them to address issues out of their direct control. This includes housing, social care, isolation and other areas imperative to improving overall health and wellbeing outcomes and minimising rising costs.*[4]

[1] World Health Organisation (WHO) 2021. *Health Equity.*
[2] Ibid
[3] Ibid
[4] Sustainable Health Review, 2019, *Sustainable Health Review: Final Report to the Western Australian Government*, Department of Health, WA, p.1. (Hereafter cited as 'Final Report'.)

Addressing the social determinants of health necessitates that health systems and professionals develop cross-sector and cross-agency collaboration and commitment, together with the community, to create solutions at multiple interaction points, including early intervention and prevention, not only once people are sick and already in crisis.

The COVID-19 crisis has made this objective all the more fundamental. One of the greatest public health lessons of the impacts of the coronavirus, both in Australia and across the globe, is that health crises disproportionately impact people living in low socioeconomic conditions, the sick and immunocompromised, and the most marginalised and excluded in our society. COVID-19 has sharpened social and economic inequities and raised important questions for public health practitioners and policy makers. In an article in the journal *Lancet*, public health researchers summarised the importance of tackling social determinants in the COVID era and beyond:

> *Moving forward, as the lessons of COVID-19 are considered, social determinants of health must be included as part of pandemic research priorities, public health goals, and policy implementation. While the relationship between these variables needs elucidating, measures that affect adverse determinants, such as…regular income support to low-income households, access to testing and shelter among the homeless, and improving health-care access in low-income neighbourhoods have the potential to dramatically reduce future pandemic morbidity and mortality.*[5]

The Sustainable Health Review (SHR), announced by the Government of Western Australia in 2017, sets strategic directions for the WA health system. In 2020, the review moved into implementation phase as the Sustainable Health Implementation Program (SHIP), managed by the Department of Health and a dedicated unit, the Sustainable Health Implementation and Support Unit (SHISU). The Implementation Briefing Plan by SHISU in September 2020 emphasised the following features of the SHR moving forward:

- Moving from a predominantly reactive, acute, hospital-based system – to one with a strong focus on prevention, equity, early child health, end-of-life care, and access to services at home and in the community through use of technology and innovation
- Requires a whole-of-government approach
- Places consumers at the centre of decision-making
- Will need cultural change, leadership, courage, and an unwavering commitment to staying the course.

Following extensive public consultation, the collaboratively organised implementation of SHIP signals that the "change [necessary to achieve health equity] is inextricably linked to creating purposeful partnerships with people, communities, industry and the non-government sector, and between levels of government to address the myriad of factors that are essential to health and wellbeing."[6]

[5] Elissa M. Abrams & Stanley J Szefler, 'COVID-19 and the impact of social determinants of health', *Lancet Respiratory*, vol.8, 2020, p.650.
[6] SHR Final Report, p. 4

This is based on the shared understanding that achieving the objectives of the SHR/SHIP, and in particular the systemic shift towards prevention and improving equity outcomes, also necessitates close engagement with the social determinants of health and thus a strategic and operational shift of the health system to develop robust, cross-sector partnerships. Strong cross-sector partnerships between government departments, public health agencies, social services and other community-based organisations are important to successfully implementing a range of recommendations in the SHR as well as working towards the systems-level outcomes it sets out to achieve. Including partners in the planning of program development and implementation from the beginning is important to leverage existing expertise and leadership, recognise where gaps and overlaps lay, and identify shared solutions and measures which can be further refined and built on across the SHR lifespan. This is even more important as the world begins to "learn to live with COVID" and in facilitating the social and economic recovery that will likely guide policy and practice for years to come.

Defining and scoping the social determinants of health

The WHO describes social determinants as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems."[7] This is similar to a definition adopted in the Final Report of the SHR, being 'the social conditions in which people are born, grow, work, play and age – that influence their health.'[8]

Some of the most important social determinants of health that are dominant in the literature include: housing and/or living environment, including the natural environment, education, income and its distribution, stress, early life and childhood development, racism, social exclusion, work conditions, unemployment, social support, addiction, food security, and transportation.[9] [10] The list of social determinants has grown substantially over recent decades, as the work of the WHO's Global Commission on Social Determinants of Health positioned social determinants as a foundational concept in the field of population and public health.[11]

As some researchers have suggested, it may be helpful in both clinical and policymaking settings to determine a set of "elementary" social determinants to prioritise for interventions.[12] The United States health initiative, *Healthy People 2020,* for example, identified five key social determinants of health to create a place-based organising framework to help establish common goals, complementary roles, and ongoing constructive relationships between the health sector and these areas (Figure 1).[13]

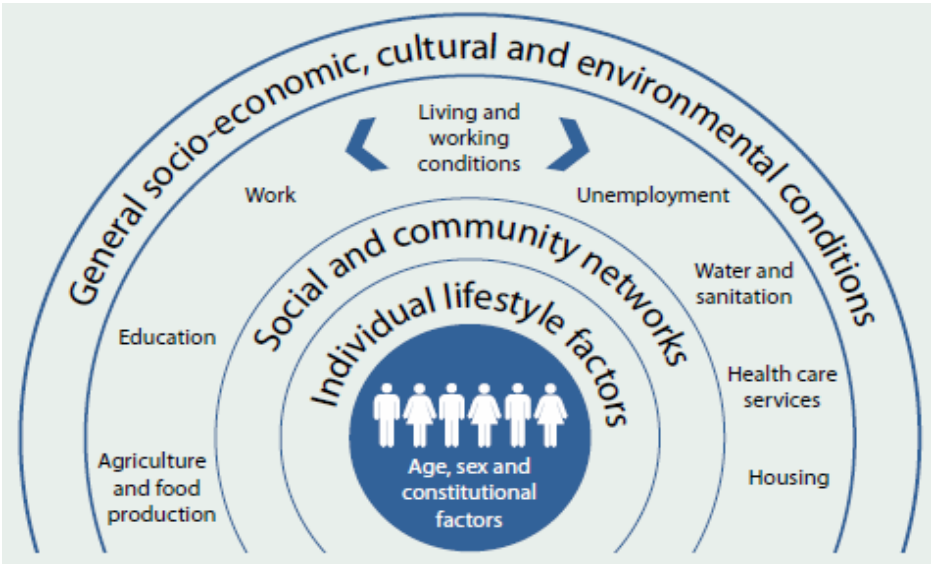
[7] World Health Organisation (2021). *The social determinants of health.* Online article.
[8] Final Report, p.133, glossary.
[9] Department of Health and Human Services (2017), Inequalities in the social determinants of health and what it means for the health of Victorians: findings from the 2014 Victorian Population Health Survey, State Government of Victoria, Melbourne.
[10] Islam M. M. (2019). Social Determinants of Health and Related Inequalities: Confusion and Implications. Frontiers in public health, 7, 11. https://doi.org/10.3389/fpubh.2019.00011
[11] Ibid.
[12] Ibid.
[13] Healthy People 2020Fi (2020). *Social Determinants of Health.* Online article.

Figure 1. Healthy People 2020 Approach to Social Determinants of Health

Source: Healthy People 2020

There are similarly a large number of frameworks defining the social determinants of health, used both in public health research and policy making. The SHR Final Report uses the social determinants framework developed by the Australian Institute of Health and Welfare (AIHW) to describe the interplay between social and economic factors and health behaviours, as in Figure 2.

Figure 2. AIHW Social Determinants of Health Framework



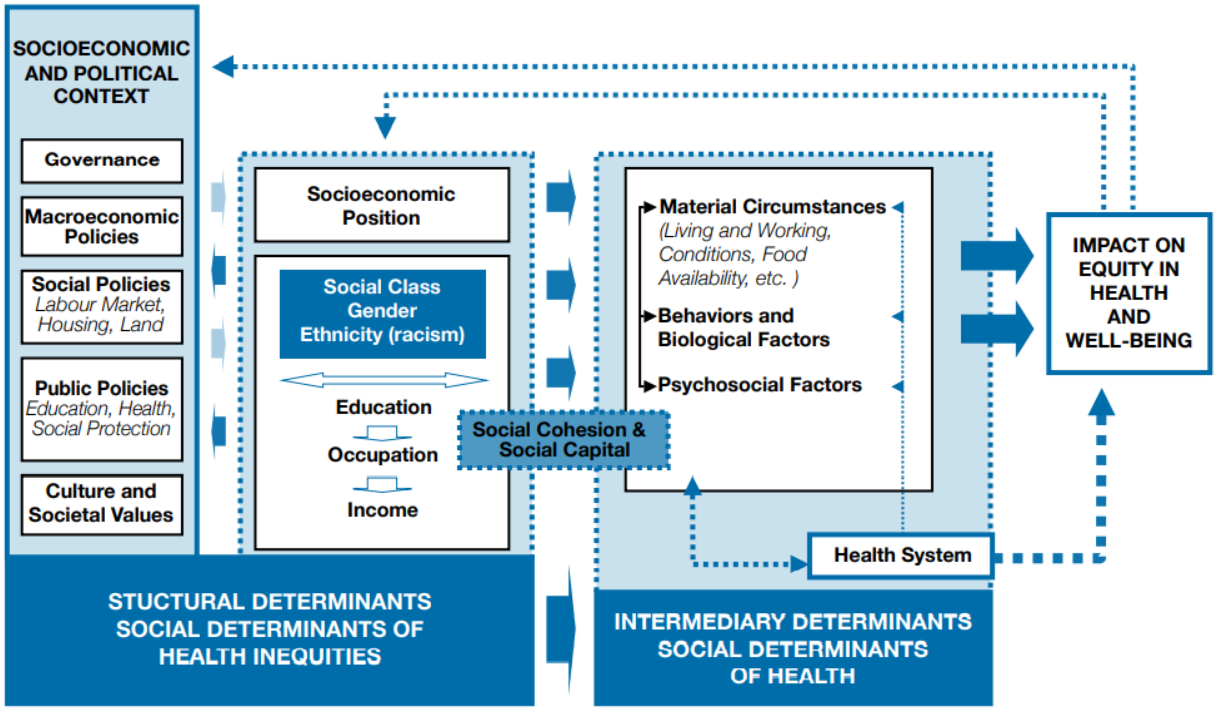
Source: AIHW, 2016, Australia's Health, AIHW, Canberra, 2016

The AIHW framework contextualises the health of individuals within social and community networks, and general socio-economic, cultural and environmental conditions. It correctly superimposes the latter as having a determining effect on the health of the individual. It is important not to

misinterpret the framework to suggest that individuals simply have choice over their social and economic position. Rather, it suggests that broader socio-economic, cultural and environmental context envelops the individual and has far more influence on their health than individual behaviour.

The WHO developed *a conceptual framework for action on the social determinants of health*[14] that extends beyond the AIHW framework to include a country's broader socioeconomic and political context. The framework distinguishes between two types or levels of social determinants, structural and intermediary. It shows how social, economic and political mechanisms give rise to a set of socioeconomic positions, whereby populations are stratified according to income, education, occupation, gender, race/ethnicity and other factors, classified as *structural determinants*. These in turn impact upon the material circumstances, behaviours, biological and psychosocial factors that impact health, classified as the *intermediary determinants*. Bridging the structural and intermediary determinants are concepts of social cohesion and social capital. The conceptual framework highlights how these levels of determinants are interrelated and compounding, resulting in differences in exposure and vulnerability to health-compromising conditions for different groups, *before* they reach the health system.

Figure 3. WHO Social Determinants of Health Conceptual Framework



Source: Solar and Irwin, 2010.

The WHO framework also suggests that *systemic change* is needed to affect the distribution of health and wellbeing, from 'big-picture' or upstream changes in governance, policy and societal values, to midstream changes in individuals' material circumstances, to downstream changes in the structure and quality of healthcare. Importantly, health behaviours and biological factors – usually

[14] Solar O, Irwin A. (2010) A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice).

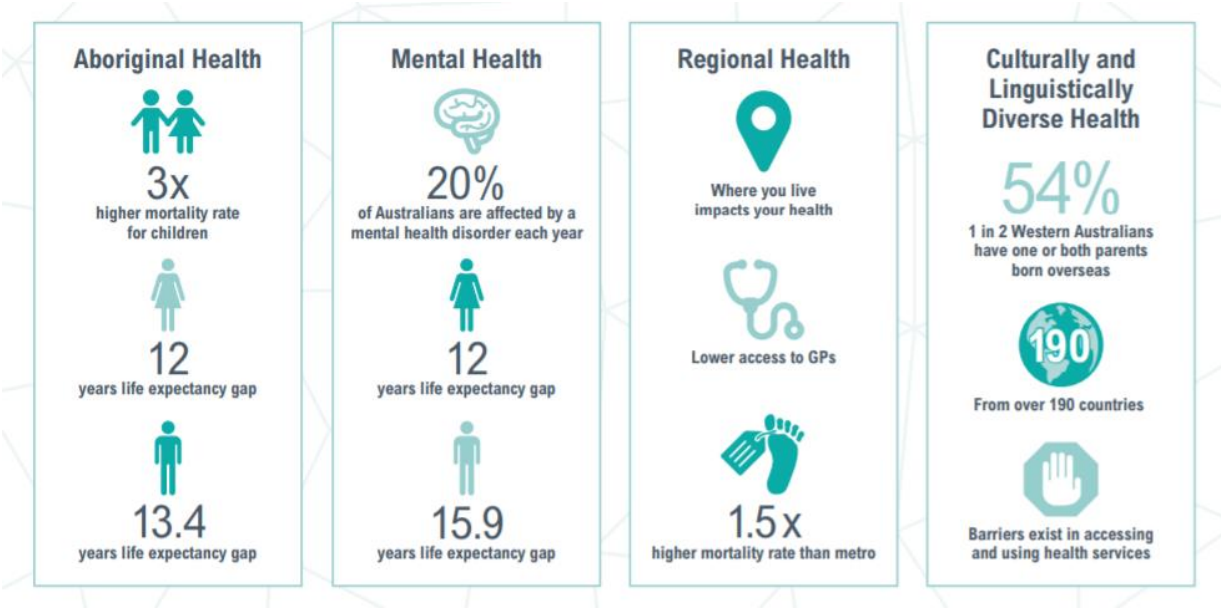
approached through the prism of individualism – are shown as being engendered by and arising from one's socioeconomic position and overlapping social structures and economic systems. Individuals are therefore unlikely to be able to directly control many of the determinants of health. This means that solutions focused solely on individual behavioural change and education that ignore larger structural, social, and other personal barriers are unlikely to shift the dial on health inequity.

There are multiple frameworks that provide unique perspectives and overarching categories to demonstrate the upstream and downstream influences on health. Recognising that each framework may explore different aspects of the social determinants of health, frameworks such as these can help clinicians, researchers and policymakers to identify levels of intervention and entry points for action on the social determinants of health. Efforts can be directed at upstream (structural), midstream (intermediary) or downstream (health system) factors. Where efforts are concentrated, however, are likely to have implications in terms of making a measurable and/or population-level impact on health inequalities.

Health inequity in Western Australia: spotlight on race and income inequality

There is a substantial body of literature outlining the health related inequalities between population subgroups in Australia. Appendix 5 in the SHR Final Report outlines key health facts and outcomes for a range of groups experiencing the greatest health inequalities in WA. These include Aboriginal people, culturally and linguistically diverse (CALD) people, people living in low socioeconomic conditions, people living in rural and remote areas, people with mental health conditions, people with disability, the LGBTIQA+ community, and people who have experienced family and domestic violence. The key statistics reveal that all of these population groups experience poorer health outcomes and mortality rates compared to the rest of the WA population.

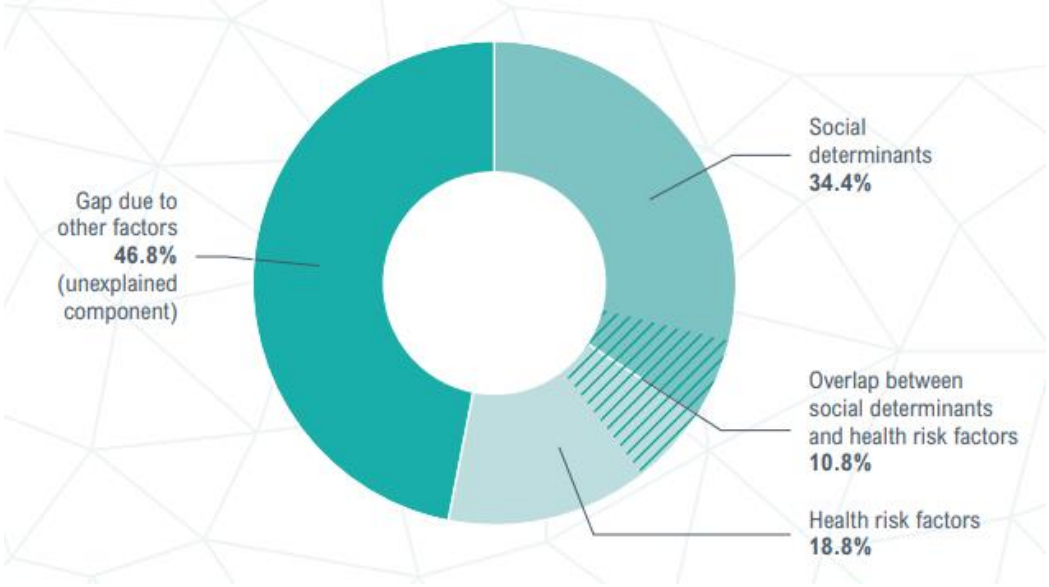
Figure 4. Key examples of health inequality in WA



Source: The Sustainable Health Review Final Report, 2019, p. 31

The social determinants of health are major considerations for policymakers in relation to 'closing the gap' of disadvantage experienced by Aboriginal and Torres Strait Islander people. As outlined in the SHR Final Report, approximately 30-50% of the health gap between Aboriginal and Torres Strait Islander people and other Australians can be attributed to social determinants of health.

Figure 5. The size and causes of the health gap between Indigenous and non-Indigenous people.



Source: AIHW[15]

The Federal Government's Closing the Gap (CTG) strategy has clearly identified some determinants as important levers to address this health gap, in particular access to health care, education and employment, and this is a crucial step to improving health outcomes for Aboriginal and Torres Strait Islander people. Literature on social determinants of Indigenous health often classify the determinants highlighted in the CTG strategy as *proximal*, while classifying others as *intermediate* or *distal* (See Figure 6). Research suggests that addressing a broader range of social determinants, including intermediate and distal, holds greater promise for meeting the CTG targets.[16]

[15] Holman D, Joyce S. A Promising Future: WA Aboriginal Health Programs. Review of performance with recommendations for consolidation and advance. Department of Health WA. Perth; 2014

[16] Southgate Institute for Health, Society and Equity (2019*). Social Determinants of Indigenous Health and Closing the Gap*. Policy Brief, Flinders University.

Figure 6. Social determinants of health for Aboriginal and Torres Strait Islander people

Negative impact of social determinants of health	Positive impacts of social determinants of health
Distal Determinants	
Colonisation, institutionalised racism	Self-determination, sovereign rights, representation
Intermediate Determinants	
Systemic racism, colonial systems, dispossession, exclusion from government and policy processes	Community control, capacities, infrastructure, resources, service systems, land rights and control over land, inclusion in policy processes
Proximal Determinants	
interpersonal racism, poor housing conditions (inc. sanitation, overcrowding), poverty, stress, social exclusion, trauma, incarceration, addiction	Individual control over lives, income, employment, education, early life experiences, access to health care, social support, food security, transport, cultural determinants
Health outcomes for Aboriginal and Torres Strait Islander peoples	

Source: Southgate Institute for Health, Society and Equity, 2019

The chronic health burden in the Australian population attributable to socioeconomic disadvantage is large; and much of this burden is potentially avoidable.[17] The 100 Families WA baseline survey[18] conducted in 2019, situates this evidence in the WA context. Table 1 depicts the proportion of 100 Families WA baseline survey participants (n=400) that report diagnosis of select chronic health conditions, compared with the Australian population rate of those conditions. The prevalence of chronic conditions amongst the 100 Families WA sample is markedly higher across all conditions than within the general Australian population. Further, 84.3 per cent of 100 Families WA survey participants reported diagnosis of at least one long-term health condition, compared to 50 per cent of the Australian population, while 68.7 per cent reported experiencing two or more chronic conditions, compared with 23 per cent of the Australian population.

In addition, 100 Families WA family members reported levels of depression, anxiety, and stress, measured by the DASS21, substantially higher than Australian general population studies. Over two thirds (69.3 per cent) of 100 Families WA family members reported diagnosis of at least one mental health condition, with the most common conditions being anxiety disorders (46.5 per cent) and depression (57.8 per cent).[19]

[17] Turrell G, Stanley L, de Looper M & Oldenburg B (2006). *Health Inequalities in Australia: Morbidity, health behaviours, risk factors and health service use*. Health Inequalities Monitoring Series No. 2. AIHW Cat. No. PHE 72. Canberra: Queensland University of Technology and the Australian Institute of Health and Welfare.
[18] Seivwright, A., and Flatau, P. (2019). *Insights into hardship and disadvantage in Perth, Western Australia: The 100 Families WA Baseline Report.* The 100 Families WA project (Anglicare, Centrecare, Jacaranda Community Centre, Mercycare, Ruah Community Services, UnitingCare West, Wanslea, WACOSS, the University of Western Australia (Centre for Social Impact and the School of Population and Global Health), Perth, Western Australia.
[19] Ibid.

Table 1. Proportion of the 100 Families WA Sample (N=400) and the Australian Population Experiencing Chronic Health Conditions

Conditions:	100 Families WA sample	Australian Population
Arthritis	30.5%	15.0%[1]
Asthma	31.3%	11.2%[1]
Back problems	44.8%	16.4%[1]
Blindness	8.3%	0.6%[2]
Cancer	9.0%	1.8%[1]
Chronic Obstructive Pulmonary Disease	5.3%	2.5%[1]
Deafness	10.5%	11.1%[3]
Dental problems	54.3%	26.0%[4]
Diabetes	18.5%	4.9%[1]
Epilepsy	5.0%	3.0%[5]
Heart, stroke and vascular disease	11.5%	4.8%[1]
Hepatitis C	7.3%	-*
Hypertension	28.5%	10.6%[1]
Kidney disease	6.8%	1.0%[1]
Liver disease/cirrhosis	7.8%	-**
Osteoporosis	11.3%	3.8%[1]

Source: 100 Families WA Baseline Report

As the authors of the baseline report highlight:

> *The relationship between income poverty and poor health can be characterised as a vicious cycle: poor health can have a detrimental effect on household income through increased healthcare costs and limited ability to partake in income-generating activities, which can create or maintain poverty, and poverty creates limitations with regard to access to nutritional food and access to health care, particularly preventative healthcare, which in turn creates or compounds ill health, and so on.*[20]

For example, 15.5 per cent of participating families reported not having access to or being unable to afford medicine prescribed by a doctor (compared to 0.5% of the general population), 14 per cent of families reported not having access to or unable to afford a substantial meal at least once per day (compared to 0.1 per cent of the general population) and 45 per cent reported not having access to

[20] Ibid.

or being unable to afford dental treatment when needed (compared to 5.2 per cent of the general public).[21]

Since many of the barriers to health care, direct or indirect, relate to an individual's financial position, many of the above issues can immediately be resolved through the raising of income supports such as Jobseeker. This outcome was demonstrated during lockdown in 2020 where, following the provision of Coronavirus Supplement payments, 52 per cent of families reported that their quality of life improved, 28 per cent of families reported that they were able to purchase sufficient and more nutritious food and 20 per cent reported that they could obtain 'other essentials' such as medicine.[22]

While the SHR specifically focuses on reducing inequity in health outcomes and access to care among Aboriginal people and families, CALD people, and people living in low socioeconomic conditions (as highlighted in *Recommendation 3),* it is important to also be attentive of the simultaneity of intersecting inequalities and their implications for social determinants.[23] Population groups experiencing the greatest health inequalities in WA are not homogenous nor static, while also potentially being interrelated and mutually constitutive. An individual, for example, may live in a rural area, in low socio-economic conditions and have a disability. There is a need, therefore, to adopt an intersectional approach to both measure and understand the impact of social determinants of health in the WA context to guide both policy and practice.

Emerging strategies to assess and measure the social determinants of health

The United States Department of Health & Human Services has called the lack of "availability of high-quality data for all communities ultimately a health equity issue."[24] Researchers emphasise the need for a shared framework for measuring the social determinants of health that can be utilised across sectors, in order to compare health outcomes across geographic areas, monitor progress, and ultimately advocate for investment in interventions that most effectively improve community health and well-being.[25] Recommendation 3 of the SHR aims to:

> *Reduce inequity in health outcomes and access to care with focus on:*
> *a) Aboriginal people and families in line with the WA Aboriginal Health and Wellbeing Framework 2015-2030*
> *b) Culturally and Linguistically Diverse (CALD) people; and*
> *c) People living in low socioeconomic conditions* [26]

---

[21] Ibid.
[22] Callis, Z., Seivwright, A., Orr, C. & Flatau, P. (2020). The Impact of COVID-19 on Families in Hardship In Western Australia. The 100 Families WA project (Anglicare, Centrecare, Jacaranda Community Centre, Mercycare, Ruah Community Services, Uniting WA, Wanslea, WACOSS, The University of Western Australia (Centre for Social Impact and the School of Population and Global Health)), Perth, Western Australia. doi: 10.25916/5f3b2a5e4bb42
[23] Lopez, N. and V. L. Gadsden. 2016. Health Inequities, Social Determinants, and Intersectionality. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/201612a
[24] United States Department of Health & Human Services. (2015). *Healthy people 2020: an opportunity to address societal determinants of health in the United States*. Washington, DC
[25] Elias, R.R., Jutte, D.P. and Moore, A. (2019) *Exploring consensus across sectors for measuring the social determinants of health,* SSM Population Health, 7, 100395. https://doi.org/10.1016/j.ssmph.2019.100395
[26] SHR Final Report, p. 11

Priorities in implementation for 3b and 3c include *improved data and benchmarks of health outcomes of CALD people*, and developing a *collective approach to improved understanding, benchmarking and targeting of health needs of people living in low socioeconomic conditions, including social determinants such as housing, child and family safety and disability support*, respectively.

High-quality, standardised, easy-to-use data is critically important to facilitate research and analysis on the social determinants of health in Western Australia, and to evaluate interventions designed to mitigate them. There is limited information, however, on the best way to collect and use such data.[27] Drawing from international research and approaches, there are multiple settings and levels, including individual, community and policy levels, at which data can be collected and analysed. A collection of datasets and analytic tools developed in Australia and abroad that can power understanding of social determinants of health are located in the appendices for reference.

Assessing Individual Social Needs and Risk Factors in Healthcare Settings

Information about patients' social and economic living conditions is not routinely collected in Australian clinical settings, but could help clinicians to better tailor patient care.[28]

Introducing a social health screening tool could allow clinicians or other healthcare professionals to gather information about constraints that some patients experience in their lives, including low income, insecure housing, available transportation or conditions of employment. This information could help clinicians develop a better understanding of patient's ability to afford appropriate medications and treatment, health service access and utilisation, potential reasons for noncompliance with clinical advice, or general adversities in patients' lives that affect how they experience illness.[29]

When utilised in healthcare settings state-wide, information from such a tool could then be fed into electronic data collection systems to facilitate and enhance research and analysis into the social determinants of health and how they affect health equity.

Community Measures and Mapping Tools to Assess Social Determinants

Healthcare systems that learn about the communities in which their patients live can adapt their services to meet the communities' specific needs.

There are an increasing number of tools available in the United States, for example, that can help people understand how the social determinants of health affect the health of a community, including measures, indices, and mapping tools to assess social conditions in a given population or location. Community health assessments (CHAs) and community health needs assessments (CHNAs),[30] for example, can be used as tools to assess the health of communities and to design

[27] Katz, A. Chateau, D., Enns, J.e., Valdivia, F., Taylor, C., Walld, R., McCulloch, S. (2018). *Association of the Social Determinants of Health With Quality of Primary Care.* Analysis of Family Medicine, 16:3, pp.216-224.
[28] Browne-Yung K, Freeman T, Battersby M, McEvoy DR, Baum F. Developing a screening tool to recognise social determinants of health in Australian clinical settings. Public Health Res Pract. 2019;29(4):e28341813.
[29] Ibid.
[30] UCI Medical Center (2019) *Community Health Needs Assessment*. Online Article.

strategies and policies to address social determinants of health.[31] Defined as "a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community,"[32] these assessments can be used to promote community engagement and collaborative participation to address community health and wellbeing needs.

A CHNA identifies unmet health needs in the service area, provides information to select priorities for action and target geographical areas, and serves as the basis for community benefit programs. This assessment incorporates components of primary data collection and secondary data analysis that focus on the health and social needs of the service area, including but not limited to, community demographics, social determinants of health, health access, health behaviours and preventive practices.

Health Impact Assessments

A Health Impact Assessment (HIA) is a tool designed to help community stakeholders investigate how a proposed program, project, policy, or plan may impact the health and well-being of a community. HIAs are generally used when a project, development, or action on the part of government or other party that conducts operations on a large scale, such as a major corporation, real estate developer or transportation company, and is thus important to consider the implications and consequences for health.

According to the United States Environmental Protection Agency, HIAs:

- *determine the potential effects of a proposed decision on the health of a population and the distribution of those effects within the population;*
- *consider input from stakeholders, including those impacted by the decision;*
- *use different types of qualitative and quantitative evidence and analytical methods;*
- *are flexible based on available time and resources; and*
- *provide evidence and recommendations to decision-makers in a timely manner.*[33]

HIAs play a role in promoting health equity by providing recommendations that maximise the potential positive health impacts and minimise and/or avoid the potential negative health impacts of a proposed project or policy.

Embedding social determinants in policy

"Although furthering our understanding of the determinants of health inequalities represents an important goal for public health, even more important and challenging is the development of policies, interventions and other initiatives to reduce inequalities."[34]

[31] Rural Health Information Hub (2021) *Using Community Health Assessments to Understand the Social Determinants of Health in a Community*. Online Article.
[32] Turnock B. (2009). *Public Health: What It Is and How It Works. Jones and Bartlett,* as adapted in Public Health Accreditation Board Acronyms and Glossary of Terms Version 1.0
[33] United States Environmental Protection Agency (2021). *Health Impact Assessments.* Online Article.
[34] Turrell at al, 2006.

While the fundamental role that social determinants have on people's health and wellbeing is widely established, this knowledge has not translated into a broader, more nuanced approach to ensuring improved health outcomes that moves beyond conventional biomedical approaches. More recent research, including some global and local initiatives (see appendices), demonstrate how communicating about social determinants can influence action across the health sector and beyond.

The SHR recognises the need for a "whole-of-government" approach to best ensure the health and wellbeing of all Western Australians and to engage in cross-sectoral and cross-agency collaboration to address the social determinants of health and promote health equity outcomes. This approach becomes even more self-evident when it is acknowledged that interventions needed to promote health equity outcomes are often similar across many social problems and sectors. For example, access to affordable, secure and stable housing contributes to child development and learning outcomes, improved management of chronic medical conditions, increased worker productivity and better mental health.[35]

The SHR Enduring Strategy, 'Reduce inequity in health outcomes and access to care with focus on Aboriginal people, culturally and linguistically diverse people and people living in low socioeconomic conditions,' acknowledges that the health and wellbeing is not the responsibility of the Department of Health alone.

> *It is clear that the WA health system cannot hope to improve the social determinants of health on its own. It is a collective responsibility to create the conditions in which people can lead healthier lives including early childhood experiences, social supports, housing and the environment, education and employment. Within the WA Government and the health and social services sectors, there is growing recognition of the need to partner to address complex factors that affect people's health and wellbeing.*[36]

In Western Australia, multiple agencies take a role in leading aspects of health and wellbeing, but better coordination of effort and investment is needed, with clear alignment between the multiple frameworks, approaches and measurement regimes. The Department of Communities, for example, and peak bodies working across social policy areas have responsibility for a range of portfolios which have direct impact on individual and public health, including child protection, community services, disability services, housing, prevention of family and domestic violence, remote Aboriginal communities, seniors and ageing, women's interests and young people, children and families. There are multiple, interconnected outcome areas across each of these portfolios. A more strategic approach to partnership and investment within the health and social services sectors requires the development of robust and reliable outcome measures across programs, agencies and disciplines, together with a shared capability to implement, measure and evaluate them.[37]

---

[35] New Zealand Government Inquiry into Mental Health and Addiction (2018). *He Ara Oranga Report of the Government Inquiry into Mental Health and Addiction*. Available online.

[36] SHR Final Report, p.34

[37] C Twomey, E Perroni, G Hansen, C Stephens and A Gregory (2021*) Beyond Recovery. Submission for the WA State Budget 2022-23*. Western Australian Council of Social Service.

Such measures should be developed in partnership with individuals and service organisations who are leaders and/or representatives of medically underserved, low-income and minority populations, local health or other departments or agencies with current data or other information relevant to the health needs of the community. This would require central oversight and advice within government, the relevant knowledge and practice within commissioning agencies and service networks, and engagement with independent expertise in research institutions. Supporting a shared data asset across research institutions and sectors that is backed by common data and measurement protocols will reduce the reliance of government on expensive one-off reports from consultants. Over time, better measurement of service and population outcomes across programs, agencies and portfolios will help leverage evidence-based policies in non-health sectors that affect social determinants of health and health equity.

Health-in-all-policies, an international movement spearheaded by WHO is an example of health lens applied to social policy making, where the returns on investment have been evaluated as contributing not just to improved physical health but overall wellbeing of people and communities (see appendix 2).

Mapping the SHR outcomes to the WA Outcomes Measurement Framework

Recruited by the Department, the Paxon Group provided advice about the design and development of indicators to monitor the impact of the implementation of the SHR. Included in the preliminary identification of measures, and combination of measures, that can be used to track progress were indicators outside of the health domain, such as indices of disadvantage, employment rates and access to culturally appropriate services, to name a few.

The WA Outcomes Measurement Framework (OMFW) was recommended to be used as the organising architecture. The OMFW is premised on an understanding that wellbeing and the idea of a 'good life' is not linear, and that their enablers stretch across all outcome domains, rather than being limited to 'health' alone.[38] By orienting to the 'outcome' that is to be achieved or strived for, rather than the 'output', it is possible to better support the particular needs of the person, and not simply measure programmatic milestones.

Figure 7. WA Outcomes Measurement Framework Domains

Source: SHR Final Report

[38] https://www.wa.gov.au/sites/default/files/2019-05/Outcomes%20Measurement%20Framework%20Prototype%204%20-%20March%202019.pdf

High level and preliminary mapping of the enduring strategies, recommendation and pillars that 'talk' to each of the domains has been undertaken (see appendix 1). Below is a graphic that gives a high level view of how SHR connects to the wider outcome measurement framework. This template is also being used in Department of Communities, meaning that there is the potential to have consistency across the templates that government use.

Conclusion

The uptake of social determinants in public health service delivery and policy development has gained momentum in Western Australia, and the SHR has been a primary driver of this change in strategy, practice and culture. The priorities in implementation outlined in recommendation 3, *reduce inequity in health outcomes and access to care,* demonstrate a need for a collective approach to improved understanding, benchmarking and targeting of health needs of groups experiencing health inequalities, particularly for Aboriginal people and their families, CALD people and people living in low socioeconomic conditions.

To achieve these priorities, the development of high-quality, standardised, easy-to-use data is critically important to facilitate research and analysis on the social determinants of health in Western Australia, and to evaluate interventions designed to mitigate them. With this shared

understanding of health inequities among different groups, and the social determinants of health that underpin them, clinicians, community organisations and the government can collaboratively partner to assess health needs and outcomes across geographic areas, monitor progress of particular policies, programs and interventions, and ultimately advocate for investment in areas that most effectively improve community health and well-being.

Appendices

Appendix 1: Outcome measures and indicators

1. Mapping WA OMFW domains and measures to SHR strategies and outcomes

Enduring Strategy	Health outcome	Other domain outcomes	Measure
ES1: Commit and collaborate to address major public health issues	**O1: Population health outcomes improved for all**	**Stable** Prevalence and impact of family violence	Rates of hospitalisations for domestic violence incidents (GOV - H) Coordinated Response Services (GOV – C)
	O2: Harmful alcohol and drug use reduced	**Equipped** Access to human and health services	Proportion of people who have difficulty accessing health and human service providers (LW tbc) Eg, Average minimum travel time to reach the nearest key services: ARIA+ classification of remoteness (NSW)
	O3: Inequity reduced	**Stable** Prevalence of food insecurity/access to safe, adequate and nutritious food	Food Stress Index (Curtin, WACOSS) Western Australia Health and Wellbeing Surveillance System (GOV – H) Foodbank Hunger Report (annual)
		Stable Rates of employment	Labour Force, Australia (ABS Cat. No. 6202.0)
		Safe Rates of discrimination	General Social Survey (ABS Cat. No. 4159.0) Commissioner for Equal Opportunity
	O6: Improved	**Safe** Rates of self-injury and suicide	Causes of death Australia (ABS)

ES2: Improve mental health outcomes	**mental and physical health outcomes**		Epidemiology – WA Health Data Linkage Branch mortality data sets WA State Coroner – reportable deaths
	O7: Care is person-centred and responsive	**Stable** Rates of homelessness	Overnight counts of people sleeping in crisis accommodation; proportion of all dwellings that are social housing; overnight counts of people sleeping rough (GOV – C)
		Connected Proportion of people who have been involved in groups	General Social Survey (ABS, sssCat. No. 4159.0)
ES3: Great beginnings and a dignified end of life	**O10: Children receive the best start to life**	**Safe** Prevalence of abuse and neglect of children	Proportion of children in the CEO's care (GOV – C)
		Equipped Children starting school ready to learn	Australian Early Development Census (AEDC) developmental domains (LW, VIC, GOV - E)
ES4: Person-centred, equitable, seamless access	**O16: Hospital readmissions are reduced**	**Empowered** Incidence of co-designed services	Frequency of consumer advisory committee meetings and evidence of consumer input into co-design of health services (GOV - H)
		Stable Support to undertake daily living	
		Connected Prevalence of community work/volunteering	General Social Survey (ABS Cat. No. 4159.0) Volunteering WA?
		Sustainable Incidence of service users in the ongoing planning, co-design and delivery of services	Delivering Community Services Procurement Policy (GOV – F) Health and MHC?
ES5: Drive safety, quality and value through transparency, funding and planning	**O23: Health system capacity meets community needs**	**Healthy** Level of patient satisfaction with health services	Health Service Performance Report (HSPR) - reported monthly (GOV - H)
		Stable Rates of homelessness	Overnight counts of people sleeping in crisis accommodation; proportion of all dwellings that are social

			housing; overnight counts of people sleeping rough (GOV – C)
		Sustainable Incidence of sustainable service delivery and organisation viability	Delivering Community Services Procurement Policy (GOV – F)
ES7: Culture and workforce to support new models of care	**O30: Staff are engaged, empowered and productive**	**Equipped** Skills and resources to contribute to the economy / engaged in learning	Education and Work, Australia (ABS Cat. No. 6227.0)

2. Mapping SHR enduring strategies and recommendations to WA OMFW domains

STABLE: WE ARE FINANCIALLY SECURE AND HAVE SUITABLE, STABLE AND CULTURALLY APPROPRIATE HOUSING

This domain recognises the irrefutable impact of financial hardship and housing instability on health. Adequate income, stable, affordable homes with secure tenure and culturally appropriate living conditions are necessary for improved health outcomes.

ES1 – O3: Reduce inequity in health outcomes and access to care with a focus on Aboriginal and culturally and linguistically diverse people, and people living in low socio economic conditions
ES8 – 28: Establish a system wide network of innovation units in partnership with clinicians, consumers and a wide range of partners to quickly develop, test and spread initiatives delivering better patient care and value.
Patient experience: Care is inclusive for all people
Quality, safety and population health: Inequity and inequality are reduced and the health and wellbeing of all Western Australians improved

SAFE: WE ARE SAFE AND FREE FROM HARM

This domain recognises that being free from injury, including self-injury, abuse and neglect are necessary for improved health outcomes. People's physical and emotional safety is also intrinsically linked to overall health.

ES1 – O2: Reduce harmful alcohol use
Quality, safety and population health: Physically and mentally healthy Western Australians with a high quality of life; The public health system provides safe, high quality care that achieves world-best standards.

HEALTHY: WE ARE HEALTHY AND WELL

This domain recognises that person-centred, equitable and seamless access to a continuum of coordinated and integrated services are necessary for improved health outcomes.

ES1: Commit and collaborate to address major public health issues
ES2: Improve mental health outcomes

EQUIPPED: WE HAVE THE SKILLS, EXPERIENCES AND RESOURCES TO CONTRIBUTE TO OUR COMMUNITY AND ECONOMY

This domain recognises that having the skills, experiences and resources to contribute to our community and economy, and feeling comfortable about the balance between what we do for ourselves and what rely on others, are necessary for improved health outcomes.

ES7: Culture and workforce to support new models of care
ES7 – 23: Build a system wide culture of courage, innovation and accountability that builds on the existing pride, compassion and professionalism of staff to support collaboration for change
ES7 – 24: Drive capability and behaviour to act as a cohesive, outward-looking system that works in partnership across sectors, with a strong focus on system integrity, transparency and public accountability
ES7 – 25: Implement contemporary workforce roles and scope of practice where there is a proven record of supporting better health outcomes and sustainability
Staff Engagement: Health system staff are valued and respected for their expertise, contribution, and dedication; Training and education ensure a highly skilled, digitally ready workforce

CONNECTED: WE ARE CONNECTED TO CULTURE, OUR COMMUNITIES, OUR ENVIRONMENT AND TO EACH OTHER

This domain recognises that connection to culture and our communities, engaging and participating in events in our community and welcoming and respecting diversity are necessary for improved health outcomes.

ES2 – 07: Implement models of care for people to access responsive and connected mental health, alcohol and other drugs services in the most appropriate setting
ES3 – 08: Health actively partner in a whole-of-government approach to supporting children and families in getting the best start in life to become physically and mentally healthy adults
ES4 – 11: Improve timely access to outpatient services
ES4 – 13: Implement models of care in the community for groups of people with complex conditions who are frequent presenters to hospital
ES4 – 14: Transform the approach to caring for older people by implementing models of care to support independence at home and other appropriate settings

ES4 – 15: Improve the interface between health, aged care and disability services to enable care in the most appropriate setting
ES6 – 22: Invest in a phased 10-year digitisation of the WA health system to empower citizens with greater health information, to enable access to innovative, safe and efficient services; and to improve, promote and protect the health of Western Australians
Patient experience: People are accessing information and services through technology to suit their needs

EMPOWERED: WE CHOOSE HOW TO LIVE OUR LIVES

This domain recognises that having access to information and processes to have our voices heard on issues that matter to us, and partnering in designing services, policies and infrastructure to meet our needs, are necessary for improved health outcomes.

ES1 – 04: Commit to new approaches to support citizen and community partnership in the design, delivery and evaluation of sustainable health and social care services and reported outcomes
ES3 – 09: Achieve respectful and appropriate end of life care and choices
ES4: Person-centred, equitable, seamless access
Patient experience: People have choices and care options; Consumers, carers and health providers are partners in team based approaches to health and wellbeing; Patient experience and feedback shapes services and holds providers accountable

SUSTAINABLE: SUSTAINABLE SERVICE DELIVERY IS SUPPORTED (as needed)

This domain recognises that Public Authorities contracting and supporting sustainable and high quality health and community service delivery are necessary for improved health outcomes.

ES1 – 05: Reduce the health system's environmental footprint and ensure mitigation and adaptation strategies are in place to respond to the health impacts and risks of climate change
ES2 – 06: Ensure clear accountabilities for joint planning, commissioning and service delivery for more integrated services
ES5: Drive safety, quality and value through transparency, funding and planning
ES5 – 17: Implement a new funding and commissioning model for the WA health system from July 2021 focused on quality and value for the patient and community, supporting new models of care and joint commissioning
ES 5 – 20: Address key short to medium term capacity pressure points and develop system planning to ensure a comprehensive long-term plan for the health system to best meet community needs
ES8: Innovate for sustainability
ES8 – 30: Ensure a robust, disciplined and integrated approach to the implementation of endorsed Sustainable Health Review Recommendations.

Staff Engagement: There is a strong identity and culture of innovation and continuous improvement to support sustainability; The health system is transparent and collaborative, open and accountable

Cost and Waste Reduction: The health system 'lives within its means' so other essential services are not adversely impacted; The health system eliminates duplication, reduces waste, and minimises its environmental footprint

Appendix 2, Emerging strategies to assess and measure the social determinants of health - resources

- Browne-Yung K, Freeman T, Battersby M, McEvoy DR, Baum F. Developing a screening tool to recognise social determinants of health in Australian clinical settings. Public Health Res Pract. 2019;29(4). https://doi.org/10.17061/phrp28341813
- The Health-Related Social Needs (HRSN) Screening Tool is a standard screening tool developed by the Centers for Medicare & Medicaid Services Center for Medicare and Medicaid Innovation (CMMI) in the United States to determine if systematically screening for health-related social needs has an effect on total healthcare costs and health outcomes. The HRSN Screening tool includes 10 items categorized into 5 domains: housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety.
- PRAPARE Implementation and Action Toolkit compiles resources, best practices, and lessons learned from health centers focused on how to implement a SDOH data collection initiative. The toolkit is accompanied by an assessment tool. The tool was developed based on a review of existing SDOH that consists of a set of national core measures to help standardize data collection.
- SDOH Data and Analytics. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/sdoh/data-analytics.html - a collection of datasets and analytic tools developed in the United States that can power understanding of social determinants of health.
- Health Impact Assessment: A Tool to Help Policy Makers Understand Health Beyond Health Care. Annual Review of Public Health 2007;28:393-412. Available from: http://www.annualreviews.org/doi/abs/10.1146/annurev.publhealth.28.083006.131942
- CDC Programs Addressing Social Determinants of Health Index - https://www.cdc.gov/socialdeterminants/cdcprograms/index.htm

Appendix 3, Case studies

Example 1: Health in All Policies (HiAP), South Australia

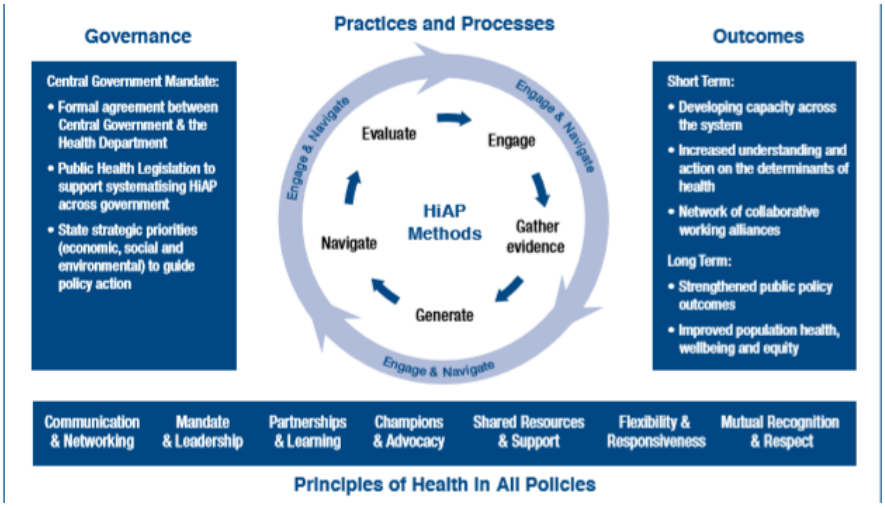
Inauguration of the World Health Organisation Commission on Social Determinants of Health in 2008 was a significant event for public health globally. As a follow-up, some governments across the world adopted the 'health in all policies' strategy to tackle the determinants of ill health and contribute towards reducing health inequities. The South Australian government had developed an identical strategy in 2007, on the recommendation of Professor Ilona Kickbusch, its thinker in residence, but extended its presence in the development of the policy globally.[39]

In 2010, the Adelaide Statement was developed by the participants, including WHO and 100 senior experts from a range of backgrounds and cultures, of the *Health in All Policies International Meeting in Adelaide 15 April 2010*. The statement outlines the need for a new social contract between all sectors to advance human development, sustainability and equity as well as improving health outcomes. It emphasises the need for a joined-up government and a new role for the health sector, and works best under following conditions:[40]

- A clear mandate makes joined-up government an imperative
- Systematic processes take account of interactions across sectors
- Mediation, negotiation and authority occur across interests
- Accountability, transparency and participatory processes are present
- Engagement occurs with stakeholders outside of government
- Practical cross-sector initiatives build partnerships and trust

In SA, the health-in-all-policies direction facilitates a cross-sectoral response that is not limited to a government agency responsible for health. Its central authority structure (under the purview of premier and cabinet) grants it a mandate to work across government portfolios.

Figure 8. HiAP model in South Australia



Source: Health in All Policies in South Australia: lessons from 10 years of practice (see footnote 12)

[39] History and background of health in all policies in SA, https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/about+us/about+sa+health/health+in+all+policies, accessed 15 February 2021.
[40] Adelaide Statement on Health in All Policies, WHO and Government of South Australia, Adelaide 2010, in *Health Promotion International*, vol.25, no.2, 2010, p.259.

Thorough evaluation and a multi-method study of the HiAP in South Australia was performed by a team from Flinders University between 2007 and 2013, and selected peer-reviewed journal articles were published in the academic press. The evaluation found that HiAP has been implemented using a combination of interrelated elements.[41] Factors that have supported early implementation of HiAP in South Australia, include:

- The provision of a resourced, centrally mandated unit, including a group of dedicated and qualified staff
- Central governance model from the Department of Premier and Cabinet which also aligned HiAP with South Australia's strategic plan and other key documents
- Establishing and maintaining trust and credibility through building relationships between staff from different agencies, learning about each other's work, and identifying common ground in HiAP
- Aligning HiAP with core business and strategic priorities of all agencies involved, as well as the broader strategic direction of the government

HiAP has been implemented in at least 16 countries around the world; report issued by WHO and SA Government details some case studies of successful implementation, and marks a 10-year anniversary of HiAP implementation in South Australia.[42]

An assessment of economic considerations in HiAP initiatives in Sweden, Canada and South Australia, based on interviews with key policy agencies and individuals implementing the HiAP, reinforced the importance of economic arguments in favour of HiAP. Economic arguments are important for promoting HiAP, particularly emphasising the long-term savings that can be made through refocusing funding on prevention strategies for tackling health inequities and improving public health. Economic evaluations are important and health economists have developed methods for incorporating health-related quality of life effects. However, HiAP benefits will also include non-health related effects, and it is equally important to evaluate these effects which also lead to improved quality of life and contribute towards better health in the long term.[43]

Example 2: Aboriginal community-controlled health sector

While it is widely understood that the Aboriginal community-controlled organisations provide culturally secure primary health services for its target population, it is little known that ACCHOs are actively invested and engaged in addressing the social determinants of health. Because Aboriginal conception of health is a holistic one, resembling the social model of health and including culture as a key determinant, biomedical models of health are at best incomplete and ineffective (and at worst, can be detrimental) when it comes to addressing significant health disparities arising out of historical marginalisation and oppression of Aboriginal communities.

[41] Tony Delany et al, 'Health in All Policies in South Australia: What has supported early implementation?', *Health Promotion International,* 2016, 31: 888-98.
[42] Carmel Williams and Claudia Galicki, 'Health in All Policies in South Australia: lessons from 10 years of practice', in *Progressing the Sustainable Development Goals through Health in All Policies, Case Studies from Around the World*, 2017,
[43] Andrew D Pinto et al, 'Economic Considerations and health in all policies initiatives: evidence from interviews with key information in Sweden, Quebec and South Australia', *BMC Public Health*, 2015, 15:271.

Aboriginal people intimately understand that health is a complex integration and balance of physical, environmental, social, spiritual and cultural wellbeing. ACCHOs provide services that impact on any aspect of health: they provide support through transport, advocacy and case management and support clients to access social services. A large advocacy role sees ACCHO peak bodies represent the communities in forums and public policy consultations that are not necessarily in service provision, but concern education, employment, justice, welfare and other key policy areas.

Culture and partnerships are major drivers of service delivery, and clinical services have a cultural element embedded in their delivery. ACCHOs are perhaps less constrained by the dominance of the medical paradigm of health because they are already positioned as a sector founded on a holistic health model of health. The Kimberley Aboriginal Medical Service uses the following model of 'mental health', or social and emotional wellbeing, for example:

Figure 9. Social and emotional wellbeing or 'mental health'

Source: *Working Together*[44]

Further, First Nations health experts such as Dr Ngaire Brown, suggest that we move away from the deficit model that is implicit in much discussion about the social determinants of health and instead take a strengths-based cultural determinants approach to improving the health of First Nations people.[45] Figure 9 illustrates how cultural determinants of health which promote a strengths based perspective, acknowledging that stronger connections to culture and country build stronger individual and collective identities, a sense of self-esteem, resilience, and result in improved

[44] Purdie, J, Dudgeon P. and Walker R, *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, Commonwealth of Australia 2014, p.57.
[45] https://nacchocommunique.com/tag/cultural-determinants-of-health-and-model-of-care/, accessed 21 March 2021.

outcomes across the other determinants of health including education, economic stability and community safety.

Cultural and social models of health for Aboriginal communities would be specific to the needs of that community and should be drawn by its members. The ACCHO sector provides a vehicle for cultural revitalisation by addressing the social and cultural determinants.