PART A – Detailed Summary (8 sections)

PART B – Key documents used for this analysis

Note: The background and methods related to this project and a comparison of all Australian jurisdictions, along with a short summary for the Federal Government, are contained in the following journal article: Newman L, F Baum & E Harris (2006), ‘Federal, State and Territory government responses to health inequities and the social determinants of health in Australia’, Health Promotion Journal of Australia, 17(3):217-225 [http://www.healthpromotion.org.au].

PART A – Detailed summary

1. THE DOCUMENTS

Several documents were recommended for analysis which had been guiding strategic directions in the Federal Department of Health & Ageing between 2000 and mid-2006. A range of other documents were also referred to by the researchers (see listing at end).

The Federal Portfolio Budget Statements 2006-07 (2005) are Budget Related Papers written to inform Senators and Members of Parliament of the proposed allocation of resources to Government outcomes by agencies within the portfolio and to help them understand the purpose of each outcome proposed in the Bills. They state the responsibilities of the Health & Ageing Portfolio, of which the Dept of Health & Ageing is one of 12 agencies (others include for example the Australian Institute of Health & Welfare, Cancer Australia, and the Private Health Insurance Administration Council). The Statements also contribute to and support organisational development and performance in portfolio agencies by identifying the Government’s key strategic priorities for the year ahead. The Statements are seen as a vehicle for public accountability, and “a clear strategic roadmap for the Department of Health and Ageing and portfolio agencies to develop and align their annual internal business planning and strategic performance reporting”. The Department’s responsibilities “for achieving the Government’s priorities (outcomes)” include population health, medical services, primary care, rural health, Indigenous health, health system capacity and quality, and private health, amongst others.

The Corporate Plan 2006-09 (2006) is a high level document identifying the key strategic directions of the Department. It is operationalised through planning and reporting tools such as the Portfolio Budget Statements and divisional business plans. The Plan says that it provides staff and external stakeholders with a snapshot of the Department’s vision, values and goals, and reflects the Government’s priorities in its fourth term of office. The Annual Report 2004-05 (2005) summarises the Expenditure, Vision,
Mission, and Highlights of the financial year for the Department of Health & Ageing. It details the Department’s activities against the performance indicators presented in the Portfolio Budget Statements for the same year.

Other non-departmental documents that were not recommended but were referred to by the researchers of this project were *Australia’s Health 2006* (2006) from the Australian Institute of Health & Welfare, *The National Chronic Disease Strategy* (2005) and the *National Mental Health Plan 2003-08* (2003) from the National Australian Health Ministers Council, and the *National Tobacco Strategy 2004-09* (2005) from Ministerial Council on Drug Strategy. Australia’s Health provides an epidemiological and statistical overview of health, including sections with disaggregated data on the health of groups such as the socially disadvantaged, rural and remote communities, Aboriginal people, and overseas-born Australians. The National Chronic Disease Strategy was written to provide a framework for national direction to improve chronic disease prevention and care, and to encourage a coordinated approach. The Strategy and its associated National Services Improvement Frameworks say they are “designed to inform senior health policymakers, health planners, peak consumer organisations, health professionals and health service managers” and that they do not target a general audience. The associated *Blueprint for Nation-wide Surveillance of Chronic Diseases and Associated Determinants* (2006) was written by the National Public Health Partnership to establish a national system to improve the quality, access and availability of information for chronic disease prevention. This was a companion document to the National Chronic Disease Strategy and was accepted by the Australian Health Ministers Council at the same time as part of a comprehensive package. The National Mental Health Plan is the third in a series to improve the mental health of the Australian community, and improve the care of people with mental illness across the lifespan. The National Tobacco Strategy 2004-09 was developed by the Ministerial Council on Drug Strategy, as part of the National Drug Strategy, as a statement of the resolve as federal, state and territory governments to work on a long-term, comprehensive, evidence-based and coordinated national plan to “reduce the misery and wasted human potential caused by tobacco smoking in Australia”.

### 2. PROCESS, DEVELOPERS, STAKEHOLDERS

The *Corporate Plan* and *Annual Report* are internal documents produced by the Department. It is unclear from the *Portfolio Budget Statements* as to how they are developed but they appear to result from Government priorities being translated into agency directions, with each agency portfolio developing performance information to determine its effectiveness in achieving agency-specific outcomes. In contrast, the *National Chronic Disease Strategy* was developed by a Working Group and Reference Group including substantial input from a wide range of university academics and members of the Consumers Health Forum, the National Public Health Partnership, and the Standing Committee on Aboriginal and Torres Strait Islander Health. It was drafted by a Professor at the University of Canberra. *Australia’s Health* is a biennial publication written by an editorial team and chapter authors from the Australian Institute of Health & Welfare. It says that critical and constructive comments were received on the 2006 draft chapters from AIHW Board members, the Australian Bureau of Statistics and the Department of Veterans’ Affairs. The third *National Mental Health Plan* was developed following evaluation of the previous plans which included “widespread community consultation, commentary by international experts and data from the National Mental Health Report”. The *National Tobacco Strategy* was prepared for the Ministerial Council by a consultant with advice from the former National Expert Advisory Committee on Tobacco and supported by the Intergovernmental Committee on Drugs.

### 3. VALUES, DEFINITIONS & LANGUAGE

Compared with the health inequities language and commitment to health equity which is evidenced extensively in the documents of some state-level jurisdictions, the Federal Department of Health & Ageing documents scarcely mention health inequities and the social determinants of health. The *Portfolio Budget Statements* do make passing comment about improving health for “low income Australians” to be comparable with that of the general population, yet this does not obviously flow from any Vision or Mission statement or strategic directions. Furthermore, this statement suggests a lack of understanding of health inequities being related to a social gradient in health. There is limited acknowledgement of the societal determinants health in the statement that “the health status of Australians depends on a number of factors, including the characteristics of the Australian economy and society as well as the activities of governments in both health and other portfolios”.

Newman, Baum & Harris (2006)
The Corporate Plan’s values focus only on values for the department and reflect the Australian Public Service Values rather than generic values like equity. The closest the Corporate Plan comes to including any mention of equity in its Values is when it says that the Department will be “working in an apolitical, fair, professional and ethical manner”. However, despite intending to work in an “apolitical” manner, the document says that is supposed to “reflect the Government’s priorities”. It also places no explicit focus on achieving equity in health. The document does talk of “working towards” improving Aboriginal health but does not mention other disadvantaged groups except the ageing. None of its goals are worded in a way that suggests any commitment to improve health outcomes or access for those with the poorest health, or that acknowledge that a variety of groups carry a greater proportion of the burden of disease (again except for the Aboriginal population).

The National Chronic Disease Strategy does includes explicit discussion about the social determinants of health and the importance for health of inclusion, strong communities and healthy environments. It also notes the need to address the disproportionate prevalence of chronic disease for certain groups, including the socioeconomically disadvantaged, the frail aged, people with a mental illness or physical disability, and Aboriginal and Torres Strait Islanders. The document’s first key principle is to “adopt a population approach and reduce health inequalities”. It also has a key direction of “focussing on health inequalities” in prevention and intervention initiatives by targeting population groups with the greatest health need. However, to some extent the rationale behind this seems to relate to financial cost and the need to reduce the burden on health expenditure, rather than the ethical focus on fairness which is prevalent in the documents of other jurisdictions. The Department of Health & Ageing was a major driver of the Strategy but the document’s explicit attention to health equity is not linked to any stated fundamental commitment to equity by the Department or the Federal Government. The associated Blueprint document aims to “inform action to address health inequalities and the needs of priority populations” and refers to the distribution of disease across population groups and geographical regions, and the need for “healthy settings”. However, going by the Department of Health & Ageing’s Annual Report it appears that the National Chronic Disease Strategy is to some extent seen as a de facto health equity policy because the Report states that “Australia continues to achieve excellent health outcomes, but many challenges remain. In the immediate future, it is anticipated that health services will be improved with the successful implementation of the National Chronic Disease Strategy. This will be particularly important for disadvantaged communities, who have a disproportionate burden of disease”.

A similar situation exists for the National Tobacco Strategy which has two major areas emphasizing the need to endorse policies that reduce smoking uptake and use by addressing the “causes of disadvantage” (noted as educational failure, family conflict and family support), and to provide tailored messages for disadvantaged groups for whom the burden of tobacco use is particularly high while barriers to service access are also high. The National Mental Health Plan mentions “principles of access and equity” in relation to access to and quality of care so that people are “not disadvantaged by, for example, being on a relatively low income, having particularly complex needs or living in a rural area”. Equity of access is also mentioned for those from culturally and linguistically diverse backgrounds”. There is one outcome which aims for “improved access for other population groups of all age groups with diverse and complex needs who are disadvantaged by geography, demographic factors, cultural and linguistic diversity, or clinical conditions” but the focus is on improving access to mainstream services rather than on addressing the social determinants of poor mental health, or the distribution of health. In fact, it says that more data is needed on the distribution of the burden/prevalence of mental health problems.

There is no indication in the Dept of Health & Ageing documents as to whether any section or department carries responsibility for health equity, but this is not surprising as health equity is not an explicit value or outcome for the Federal Government or the Department.

4. **HEALTH OUTCOMES AND HEALTH ACCESS**

The Portfolio Budget Statements outline general and specific targets to improve health outcomes such as improved life expectancy and infant mortality. In this regard, they say that the Department aims for “continued improvement in life expectancy for both males and females over time” for “further reductions in infant mortality rates”, and for “improved life expectancy, health expectancy and infant mortality rates for Aboriginal and Torres Strait Islanders, so that they are comparable with the general population” and

Newman, Baum & Harris (2006)
for “improved life expectancy, health expectancy and infant mortality rates for low income Australians, so that they are comparable with the general population”. The Statements also say that “The Department will give priority to addressing the challenges faced by Australia’s health and ageing systems including the rising human and financial cost of chronic disease, ensuring equitable access to health and aged care services for all Australians, and raising health outcomes for Indigenous Australians”. Other initiatives aim to improve health but do not target disadvantaged groups. For example, Strengthening Cancer Care aims to increase quitting smoking during pregnancy, but contains no detail to suggest that this will be targeted to groups with the highest smoking prevalence (such as teen mothers or women from low income areas) or that it will address the social determinants of smoking rather than simply the end behaviour. Similarly, the Portfolio Budget Statements’ Departmental Outcomes assessment states that priorities for 2006-07 will focus on “the main causes of preventable disease including poor nutrition, physical inactivity, tobacco use and alcohol misuse, with an emphasis on preventing disease associated with obesity, particularly childhood obesity” but does not target these to the populations which evidence the greater burden of disease. The key outcomes in the Statements include “reducing the incidence of preventable mortality, illness and injury”, and “improved health outcomes for Australians living in regional, rural and remote locations”.

In contrast, The National Chronic Disease Strategy says that there is a need to deliberately focus on the needs of population groups that are disproportionately affected by chronic disease (and this has already been elaborated on in the previous section in relation to this Strategy). In terms of health equity, the document does refer to AIHW data which shows that the socioeconomically disadvantaged in Australia have the worst health. There is nevertheless little explicit discussion of the needs of socioeconomically disadvantaged groups in general that might make transparent an intention to address health inequities. The document does contain strategies to address Aboriginal health, with one strategy to address Indigenous Needs through the National Illicit Drugs Strategy, which will include capacity building in Indigenous communities (with funding of $2m per year over 4 years). However, it is not clear how improved health outcomes will be monitored and evaluated to show that health inequities are being reduced for the Aboriginal communities involved. The Portfolio Statements say that the Federal Government is also committed to providing “high quality affordable care” for the ageing population, and access to health and aged care in rural areas, along with improved health status for ATSI peoples. Under “Addressing Indigenous Needs - Indigenous health - Healthy for Life” there is an aim to improve access to primary care for Aboriginal and Torres Strait Islander people.

The Portfolio Budget Statements suggest that the main Departmental contribution to improving outcomes and access for low-income or socially disadvantaged groups is through the Government’s commitment to “ensuring community access to affordable medicines through an effective, sustainable Pharmaceutical Benefits Scheme”, and continuing access to primary care services through the funding of the Medicare universal health system.

The Corporate Plan aims to achieve “better health for all Australians” and to improve health outcomes by focussing on “the national priority areas”. It notes the need to improve health outcomes, health access and quality of life for the Aboriginal population, the aged, and rural communities, but does not mention socioeconomically disadvantaged groups in general. The Corporate Plan provides a selected list of key priorities for 2006-09, which include “best practice handling of chronic disease” but it does not follow the National Chronic Disease Strategy in explicitly listing the reduction of health inequities among its top priorities in this respect.

The Annual Report has a stated aim to achieve “more equal distribution between localities” under the Medicare Benefits Schedule (MBS) because “MBS outlays per capita continue to be lower in rural and remote areas, although the relationship to the national average has improved in recent years” (and it provides data that shows this improvement). In the Department’s Outcomes Summary there are stated intentions for the Population Health Division to focus on reducing chronic disease and unhealthy lifestyle behaviours. However, whilst the targeting of people at higher risk is mentioned, there is no evidence that this stems from a fundamental commitment on the part of the Federal Government to reducing health inequity on moral grounds, as opposed to aiming to reduce the financial burden on the health system eg:

“Support will also be provided for people at high risk of chronic disease through individual and group lifestyle counselling and education services, including education and training for health and

Newman, Baum & Harris (2006)
other professionals delivering lifestyle advice. These activities will complement the other three priority areas of the Initiative – supporting early detection of risk factors and chronic disease; encouraging active patient self management, and improving communication and coordination between care services. In 2006-07, the Department will continue to implement national initiatives to reduce smoking rates and prevent youth uptake, and reduce risky and high-risk drinking. This will include previous Budget commitments to a National Youth Smoking campaign and Smoking During Pregnancy initiative, as well as a new Alcohol Campaign to encourage responsible alcohol consumption”.

Furthermore, such comments suggest that the focus in improving health is on educating individuals and finding individual solutions, rather than on structural factors which influence the broader social determinants of health or the environments in which people live their lives and/or make their choices.

5. STRATEGIES FOR ACTION: HEALTH

The Federal Department of Health & Ageing has no specific plans to address health inequity, although the National Chronic Disease Strategy does list a range of national prevention strategy documents which includes the “National Drug Strategy: Aboriginal & Torres Strait Islander Peoples Complementary Action Plan 2003-06”. Apart from addressing Aboriginal health needs, there is minimal Federal focus on improving health outcomes or access for socioeconomically disadvantaged groups or areas.

The Portfolio Budget Statements outline the outcomes and outputs developed for the Health & Ageing portfolio. There is one stated aim targeted at non-metropolitan areas to “improve the level of access to medical services, particularly in rural and regional areas, with continuing expansion of radiation oncology services especially outside major centres”. Under one Program that is mentioned (Program 3.2: Alternative Funding for Health Service Provision), it states that “the Australian Government provides funding to ensure Australians access essential medical services that would not otherwise be available. The contribution to the outcome is measured by the number of Australians from high risk and special need population groups accessing health services, scientific aids and lifesaving medical treatment overseas”.

The National Chronic Disease Strategy clearly aims to develop strategies for action that will reduce health inequities by improving health outcomes for disadvantaged groups. For example, it talks of the need to improve attendance at health screening programs. Key direction 15 is to “improve screening and early detection opportunities and uptakes for high risk population groups, such as older Australians, ATSI, and people who are socio-economically disadvantaged”. It also states that approaches that specifically target the highest risk groups must be prioritised to reduce the health inequalities and that such approaches should be supported by broader universal and environmental measures that benefit the whole population. The National Tobacco Strategy stated that individual states and territories were to develop their own Action Plans describing efforts to meet the challenges outlined in the national document. The National Mental Health Plan does include outcomes to improve access to services for those with poorer mental health, but does not address the distribution of health or the social determinants.

TARGETING CHILDREN AND REFUGEES

CHILDREN

The key Federal documents do mention children’s health as a way to improve health over the life course and adult health outcomes. A long list of strategies relating to Child Health is provided on the Department of Health & Ageing’s website. Whilst this site claims that “most Australian children are healthy and doing well, it also says that “we can always do better”. It also claims that “we have a good record in child health with significant achievements over the last few decades. For example, over the last 20 years we have reduced child mortality rates by half, and have increased immunisation coverage rates for one-year-olds from 53% in 1989-90, to over 90% since 2000”. There is however no indication as to whether these improvements have been spread equally across all population groups. There are several Federal frameworks and policies that have specifically targeted children, such as the National Childhood Nutrition Program and the National Agenda for Early Childhood (Dept of Families & Communities). The Childhood Nutrition Program was a 3 year community grants program targeting the nutrition and long term eating patterns of children to 12 years of age, and pregnant women. However, although high priority was given to projects in rural and remote communities, Aboriginal and Torres Strait Islander
communities and lower socio-economic communities, grants were allocated as long ago as 2000 and it is unclear where the emphasis on health equity derived from. The National Chronic Disease Strategy particularly emphasizes the need to attend to health across the lifespan, and the role that poor health in childhood has as a behavioural and social risk factor. Key direction 2 focuses on health promotion and risk reduction starting early in life and says that children most at risk of adverse early life events (low birthweight, exposure to tobacco smoke, malnutrition) require ongoing support to reduce health inequalities later in life. Key direction 6 focuses on promoting health and wellbeing during the school years.

REFUGEES
There is little mention of refugee health in the Federal Department of Health & Ageing documents, despite 5,500 refugee visas being granted in Australia in 2004-05 (for “people subject to persecution in their home country and in need of resettlement”), and 6,000 places being allocated for 2005-06 (plus another 7,000 places under the Special Humanitarian Programme for people “subject to gross violation of human rights in their home country”). The Dept of Health & Ageing documents contain some statements about “people from culturally and linguistically diverse backgrounds” which could include refugees. For example, the “Lifescripts Resources” is to be adapted for use with Aboriginal and Torres Strait Islander people and “people from culturally and linguistically diverse backgrounds”, and the Youth & Illicit Drug Use Strategy is also to include information for “people from non-English speaking backgrounds”. However, it is mainly the National Chronic Disease Strategy that explicitly mentions refugees, including them as a specific group among culturally and linguistically populations who have special needs or disadvantage, and noting that they may have particularly special needs if they have been victims of torture or trauma. It also notes that they may have different expectations and definitions of health, and require assistance with self-management so that interpreters and culturally appropriate practice may need to be considered.

6. STRATEGIES FOR ACTION: OTHERS INVOLVED
As with all other jurisdictions, the Federal documents acknowledge that health cannot be solely the responsibility of the Department of Health. The Portfolio Budget Statements, for example, state that “The Department will pursue improved health outcomes for Indigenous people through the new whole-of-government arrangements for Indigenous policy development and service delivery”. The National Chronic Disease Strategy highlights the fact that an effective response to addressing the prevalence of chronic disease requires a whole-of-government and whole-of-community collaboration. It also states that this is required in order to address the social determinants of health which are related to Chronic Disease.

7. IMPLEMENTATION
The main Departmental attempt to improve health outcomes and access for low-income groups is implicit in the desire to maintain accessibility to affordable health care through funding of the Medicare universal health system and the Pharmaceutical Benefits Scheme. However, the Annual Report notes that the Medicare Benefits Schedule still requires more equitable distribution between localities. The Annual Report makes claims (without supplying evidence) that improvements are being made. For example, it states that the Department “improves access to high quality comprehensive primary health care and population health programs for Aboriginal and Torres Strait Islander peoples”. Another general claim without data evidence is that “in 2004-05, the Department contributed to a reduction in incidence, prevalence and mortality rates of diseases and conditions by implementing programs and strategies that address risk factors and promote the early detection of diseases and conditions”.

Where specific initiatives and strategies are reported on, breakdowns are often just for ATSI people rather than disadvantaged groups. Furthermore, retrospective reporting of numbers of services is used more often rather than quantitative indicators of improved health outcomes or access for disadvantaged groups that would highlight the reduction of health inequities, or the achievement of pre-set targets or benchmarks. For example, the Annual Report reports that “specifically targeted maternal and child health programs have produced declines in preterm births from 16.7 per cent to 8.7 per cent, a rate comparable with the general population”, yet it does not state whether this applies to the whole ATSI population, or just a small number of women. Similarly, it reports that “7,759 Aboriginal and Torres Strait Islander adults received a health check from May 2004 to May 2005” but does not indicate what proportion this
represents of the total ATSI population and whether this is an improvement over previous figures. Similarly, in terms of mental health literacy in schools, the Report says that the Department has strengthened resources for schools within a whole school promotion of mental health, and that 86% of secondary schools are taking up professional development to use the MindMatters mental health program. Again, in terms of health equity it would be preferable to indicate what percentage of these schools were in disadvantaged areas. It also reports that “the National Child Nutrition Program’s 109 community projects were delivered in childcare centres, schools, and health care centres to improve the nutrition and long term eating patterns of children, adolescents and pregnant women in high need communities. In 2004-05, 104 of these projects were completed”, but there is no measure of the projects’ effectiveness in improving nutrition and eating patterns. Another indicator is to measure the proportion of national population health strategies that take account of the needs of specified high need groups including regional and rural Australians, Aboriginal and Torres Strait Islander peoples, people of lower socioeconomic level - particularly children and young people. However, again, this does not include mention of concrete health initiatives or improved outcomes for these groups.

There is some evidence that some programs were to be funded that would address health inequities. For example, in relation to Outcome 6 in the Portfolio Budget Statements (“Improved health outcomes for Australians living in regional, rural and remote locations”), it says that the “Rural Health Services Program is to increase access for people living in rural and remote communities to a range of health services” and allocates $104 million. The related “non-numeric target” is that “existing Regional Health Services are maintained [and] additional remote services are developed”. Similarly, $377 million is allocated for Outcome 8 to improve access by ATSI peoples to primary health care, substance abuse services and population health programs.

8. EVALUATION

As with most other jurisdictions, the Federal Department of Health & Ageing has stated aims to improve the monitoring, evaluation, target setting and achievement in relation to health outcomes and access. The Portfolio Budget Statements say that “agencies work towards whole-of-portfolio targets in relation to the health status of Australians”. Some of these targets are measured by increases in the number of episodes of access and number of services which specifically target disadvantaged areas or groups (in particular the aged, ATSI peoples, and remote areas):

**Goal:** Redeveloped or improved clinics in remote areas.  
**Measure:** Clinics are redeveloped or improved through the capital works program.  
**Outcome:** At least 18 new clinic redevelopments or improvements.

**Goal:** Increase in the number of Aboriginal and Torres Strait Islander people studying in health–related disciplines.  
**Measure:** Scholarships awarded to Aboriginal and Torres Strait Islander students through the Peggy Hunter Memorial Scholarship Scheme.  
**Outcome:** At least 60 Aboriginal and Torres Strait Islander students receive scholarships.

**Goal:** Provision of operational residential places for persons aged 70 years and over  
**Outcome:** The provision of 88 residential places per 1,000 persons aged 70 years and over.

This last goal is related to a target directed at a combination of these groups ie “availability of service provision for frail older people from diverse cultural and linguistic backgrounds ,older Aboriginal and Torres Strait Islander peoples, veterans and older people in rural and remote areas”. It aims for progress in implementing strategies to strengthen access for special needs groups and providing culturally appropriate aged care, and states that data and information on these groups is to be incorporated into planning for aged care.

Others goals provide no indication that the outcomes should be targeted to groups or areas who are socioeconomically- or health-disadvantaged eg:

**Goal:** Demonstrated access to culturally appropriate social and emotional wellbeing and mental health services.

Newman, Baum & Harris (2006)
Measure: Number of episodes of care provided.
Outcome: At least 90,000 episodes of care provided.

Goal: Uptake of the Healthy for Life initiative.
Measure: Number of Healthy for Life sites established.
Outcome: At least 42 Healthy for Life sites established by the end of 2006-07.

Goal: Families and singles qualify for reduced patient co-payments under the PBS safety net.
Measure: Number of families and singles that qualify for reduced patient co-payments under the PBS safety net.
Outcome: 1.2 million families and singles qualify; 7.1% increase in expenditure on the PBS in 2006-07.

Goal: Efficient Medicare safety net.
Measure: Number of families and singles that benefit from the extended Medicare safety net.
Outcome: An estimated 446,000 families and 120,000 singles benefit from the extended Medicare safety net in calendar year 2006.

As with other jurisdictions, the data highlighting health inequities by socioeconomic status or other indicators of disadvantage and change which are provided in compendium publications such as Australia’s Health are therefore not used in sub-targets or performance indicators that could make transparent any change in the distribution of health outcome or access. Nevertheless, the Portfolio Budget Statements say that these publications do “measure performance against the whole of portfolio targets that include reductions in infant mortality for ATSI, and improved life expectancy, health expectancy and infant mortality for low income Australians”. However, a general lack of disaggregated reporting is particularly obvious in relation to some targets which aim for a reduction in unhealthy behaviours. Whereas the National Chronic Disease Strategy highlights the need to not only use whole of population approaches but also to target groups with the higher burden of disease, the Federal goals do not acknowledge the uneven distribution of the behaviours and health outcomes involved and hence set no sub-targets to indicate whether the health gap in these behaviours is narrowing or widening between socio-economic groups. An obvious example is in relation to smoking/drugs:

Goal: Reducing harm from smoking/illicit drugs.
Measure: Number of Australians using tobacco or illicit drugs and/or consuming alcohol at risky levels.
Outcome: Continued reduction in the population using tobacco or illicit drugs, and/or consuming alcohol at risky levels.

In the Corporate Plan some quantitative targets are set which generally address social determinants of health. For example, “greater than 86% of secondary schools participating in ‘MindMatters’ mental health literacy program”, however this is not linked to also measuring participation rates for groups or areas at greater risk of poor mental health (again, except for Aboriginal people). As with all jurisdictions, there is recognition of the need to evaluate the effectiveness of programs to improve ATSI health, and a specific “Aboriginal and Torres Strait Islander Health Performance Framework” has been established to measure the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health. This has 90 measures in three groups, one of which is “health status and outcomes”, the second “determinants of health including socioeconomic and behavioural factors”, and the third “health system performance”. It would be encouraging to see a similar Federal Strategic Framework and performance assessment framework in relation to health inequities beyond ATSI health.

The National Chronic Disease Strategy says that a National Health Performance Framework is to report on three similar tiers of indicators and provides the following details which suggest that progress on reducing health inequities may become transparent through these:

1. Health status and outcome – including life expectancy, eg “is it the same for everyone”, where is the most opportunity for improvement?”
2. Determinants of health – environmental, socioeconomic factors, etc – “are factors determining change for the better, where and for whom are they changing for the worse?”

3. Health system performance – what progress in improving health of all, is it the same for everyone?

The National Chronic Disease Strategy’s associated Blueprint was written to inform Australia’s response to “the growing burden of chronic disease” by overcoming the currently “limited evidence base”, which it says is informed by a range of disparate health data collections across the nation. Its goals include improving the scope, coverage, access, analysis and application of data on chronic diseases and associate determinants, and ensuring consistency in content. It also highlights the need to make data available on “priority populations”. Furthermore, the Portfolio Budget Statements state that there was a need to improve the quality of information obtained, for example on access to Medicare benefits by ATSI peoples, and that the “voluntary Indigenous identifier” introduced in November 2002 by the Department has improved this. A voluntary “refugee identifier” might do the same for refugee groups.

PART B – Key documents used for this analysis

Recommended by Colin Sindall, Senior Advisor, Population Health Division of the Federal Australian Government Department of Health & Ageing.

Department of Health & Ageing


Also referred to:


Department of Health & Ageing. National Child Nutrition Program

http://www.immi.gov.au/media/fact-sheets/02key_1.htm#a6

National Australian Health Ministers Conference (2005) *National Chronic Disease Strategy*


*National Smoking And Pregnancy Advisory Group*