PART A. DETAILED SUMMARY

The Department of Health & Human Services’ (DHHS) Manager of the Policy Unit in Community Population & Rural Health recommended five documents that had been guiding the department’s strategic directions from 2000 to mid-2006.

1. THE DOCUMENTS

Tasmania Together 2020 (and its Review) were written as a vision and measure of progress to the Year 2020, based on “the wishes of the people”. The consultation process showed that improving health and wellbeing was an essential component of the community’s vision for the future. The document is seen as an important means of gauging “community” needs, and of “galvanising” inter-sectoral action to address these. It includes 24 goals and 212 benchmarks reflecting the concerns that Tasmanians expressed about long-term social, economic and environmental futures. The document is supposed “to guide decision-making in the government, business and community sectors”. Tasmania Together is not a government document, although the DHHS contributes to it. It is looked after on behalf of “the community” by the Tasmania Together Progress Board which oversees regular updates and makes recommendations to Parliament. The board reports regularly to “the community” on
progress against goals and targets, and where changes might be needed. The priority placed on Aboriginal health and wellbeing in Tasmania is demonstrated by the relative prominence of Aboriginal issues in Tasmania Together. The Tasmanian Government and its agencies are required to report regularly on action towards achieving the Tasmania Together goals, and goal 10 is to “acknowledge and respect the contribution that the Aboriginal community and its culture have made and continue to make to Tasmania and its identity”.

Reducing chronic conditions and associated risk behaviours are a feature of Tasmania Together’s goals and targets. However, the DHHS itself developed the document *Strengthening the Prevention and Management of Chronic Conditions: Policy Framework 2005* to guide its planning, action plans, programs and services in a consistent and comprehensive way to address the prevention and management of chronic. The framework defines concepts and terms so that “all sectors have shared understandings”. The document provides an appendix which clearly maps the relationship between Tasmanian and national policies and initiatives. The *Aboriginal Health & Wellbeing Strategic Plan* (AHWSP) is a broad strategic policy document specifically focusing on enabling the DHHS to respond to inequities in Aboriginal health and wellbeing by guiding the development of action plans by relevant service areas, in conjunction with Aboriginal Tasmanians. It says that it “builds up upon various other policy developments at the national and state levels over the last few years and reflects the Tasmanian Government’s commitment to progressing the reconciliation agenda”. The Plan says it is the major focus for the Department’s Strategic Priority on Aboriginal Reconciliation and an important vehicle for progressing the policy frameworks *Strengthening the Prevention and Management of Chronic Conditions*, and *Strengthening Primary Health and Community Care*. The Plan says it provides a more detailed and agency-specific response than the Tasmanian Aboriginal and Torres Strait Islander Health Regional Plan 2003-2005.

The *Tasmania Food & Nutrition Policy 2004* is a broad strategic policy document with a specific focus on health equity, which is accompanied by an *Action and Monitoring Plan* (which aims to address the policy’s goals and sub-goals). Together these provide a strategic framework for action in “promoting a healthy and safe farm-to-fork food supply for Tasmanians” and to “develop a food system for Tasmania that contributes to the reduction in costs of diet-related disease and food-borne illness”. The Policy endorses the broad goals of Tasmania Together by integrating food and nutrition with the broader social determinants of health and through its partnership approach with non-government, private sector, and consumer interests. It also refers to the national strategy *Eat Well Australia* and the *National Aboriginal & Torres Strait Islander Nutrition Strategy & Action Plan*. The Premier’s Physical Activity Council’s *LIVE LIFE Get Moving: Tasmania Physical Activity Plan 2005-2010* is another broad policy document with some focus on health inequity. It was developed in reaction to Goal 5 in Tasmania Together (“to prevent poor health and encourage healthy lifestyles”) and aims to encourage regular physical activity. It was developed following recognition that Tasmania has the second lowest participation rate in exercise, sport and recreation. The document is designed as a framework for coordinating the implementation and resourcing of government and community so that they can work together to achieve this vision. Live Life:Get Moving also comments that physical activity provides economic benefits by attracting tourism, becoming a means of transport, reducing absenteeism and reducing crime.
2. PROCESS, DEVELOPERS, STAKEHOLDERS

Tasmania Together is said to be “pioneering project” because it “allows the people of Tasmania a voice in what they want for their long-term social, economic and environmental future”. It is seen as “a world-leading system of community goal setting and measurement of progress” enshrined in law and used to guide decision-making in the government, business and community sectors. In August 2005 the Tasmania Together Progress Board invited all Tasmanians to have a say in their future by contributing to the first 5 Year Review of Tasmania Together. The Board says it wanted to reach a broad range of people including families, younger and older people, Tasmanian Aborigines, community groups, unions, the University of Tasmania, and the media. A wide range of input was encouraged through focus groups, newspaper and television advertisements, public launches, reply paid questionnaires, and a 1300 inquiry number. Over three months the Board took comments from all parts of the State and all sectors of the community, including:

- Almost 10,000 people who caught the information bus which visited 90 places in 80 days.
- 1,555 people who returned written questionnaires and 740 people who responded electronically.
- 15,409 visits to the website between September and December
- 73 people who participated in an online forum.
- 90 formal submissions which were received from individuals and organisations.

Other input came from consultations and surveys conducted in 2004-05 and 2005-06 which related to ageing, hardship, natural resource management, business development and passenger transport.

The Chronic Conditions Policy Framework says it was developed because the DHHS identified the prevention and management of chronic conditions as one of its major strategic priorities, and because reducing chronic conditions and the risk behaviours influencing them are also part of the Tasmania Together goals and targets. However, there is no evidence as to who developed the document. The Aboriginal Health Strategic Plan says it was developed by the DHHS in response to issues identified through consultation with Tasmania’s Aboriginal communities, through Departmental planning processes and other Government initiatives relating to Aboriginal health. It says that the consultation provided advice on how problems that affect the Aboriginal community should be addressed. Part of the dprocess included consideration of national and state initiatives. (A broader document also exists - the Tasmanian Aboriginal and Torres Strait Islander Health Regional Plan 2003-2005 developed by the Tasmanian Aboriginal Health Forum in response to the Commonwealth-State-Aboriginal Community Sector Framework Agreement on Aboriginal and Torres Strait Islander Health).

The Food & Nutrition Policy says it was reviewed and redeveloped by the DHHS in 2002. This process included submissions from key stakeholders and interest groups, along with key stakeholder forums across the state attended by over 130 people including farmers, food manufacturers and retailers, hospitality and catering workers, health professionals, teachers, peak industry organizations, and consumers. This generated key focus areas for the Policy and helped formulate the vision and guiding principles. A Steering Committee of people with interest or expertise in food and nutrition oversaw the Policy redevelopment with expert working groups providing specialized advice. The draft policy was placed on a community consultation website with a feedback guide and was advertised in newspapers. Thirty responses were received. The policy was then endorsed by the Government, but its promotion and implementation remain the responsibility of the Steering Committee. An accompanying
Action & Monitoring Plan was developed with input from key stakeholders and experts in food and nutrition. It contains intended outcomes and outcome indicators for the goals and sub-goals for the 12 focus areas. For each outcome indicator a lead Government Department is designated responsibility for reporting against the indicator on action taken to address the goal and sub-goals.

**LIVE LIFE Get Moving** was developed in late 2004 after the Premier’s Physical Activity Council saw a need for a state-wide plan. Its development included “extensive consultations held around the State with key government and non-government agencies and community representatives”. Approaches used in the plan were identified by a report from Deakin University entitled “A Review of Potential Strategies for Reducing Inactivity in Tasmania” (Salmon 2003). This says that these approaches were supported by the themes identified through the eight regional forums conducted by the Council, and included identification of workplace, primary care and schools as important settings for physical activity.

### 3. VALUES, DEFINITIONS & LANGUAGE

The documents analysed for Tasmania demonstrate a commitment by the Tasmanian government and DHHS to improve health and wellbeing for the whole population, as well as to improve living standards and health for the disadvantaged. However, health equity and social determinants of health are not as explicit in the values, objectives and outcome measures in the DHHS or broader government documents as they are in some other jurisdictions, except in the **Chronic Conditions Policy Framework**. Where health inequities language is used in DHHS documents, this is not reflected to the same extent in the whole-of-government documents. There is nevertheless still a strong implicit emphasis on the role of social determinants of health and the importance of social capital and community cohesion in creating a healthy, harmonious and economically prosperous state.

**Tasmania Together 2020** and its 2006 Review do not use the words “health inequalities” or “health inequity”, etc. However, the Rationale statements for each benchmark contain an implicit aim to improve the social determinants of health and to address factors that affect health equity. The documents talk of “fairness” and “equity”, and of targeting “disadvantaged” groups. For example, in relation to “food”, the documents state that “it is unacceptable that one in every ten households cannot afford to buy enough food”, and in relation to finances that “lack of control over financial security is directly related to poor quality of life”. They also state that “Fairness and equity are key planks of our society”. The 2006 Review notes that in community consultations people were “very clear” about, and regularly raised issues of importance such as, “the importance of lifestyle, community connections and cohesion, and the need for fairness and assistance for those who are disadvantaged; our physical and mental health; literacy and training opportunities; work; competition and infrastructure development; our natural assets, climate change and other environmental issues”. The review Board also noted that alongside “positive comments about how Tasmania has changed in the last five years” it also heard “concerns about the widening gap between rich and poor, skills shortages, sustainable resource management, and accountable government”.

Among the key issues identified in the review was a “stand out new issue” of the cost and availability of housing, followed by transport and petrol price rises. The social determinants of health and need to address equity issues in general are also highlighted in the Review’s statement that many other community comments were about family life, equitable access to basic services, and a concern for lower income and other disadvantaged members of the community (such as families “doing it tough”
and single parents), intergenerational unemployment, people facing particular and multiple disadvantages and disabilities, and ease of access to information about services for disadvantaged people and those in rural communities. Towards the end of the consultation period people also talked more about the possible impact of changes to industrial relations legislation. The Review states that “education and training” ranked with health as a standout issue for the community, and that many people were concerned about a decline in basic standards and skills shortages, as well as issues of equitable access, rural disadvantage, and attendance/retention of children from disadvantaged households. In relation to “community”, the issues revolved around the need for improved community involvement, engagement, connectedness, cohesion, support, common goals and values, community organisations and volunteering.

The Chronic Conditions: Policy Framework in its early pages talks not only about the influence of health conditions per se (the presence of chronic disease or illness), but also about the influence of social conditions on health (such as family violence and homelessness). It also talks explicitly about health inequities, defining them as “differences between actual and optimal health that are both avoidable and unfair” and notes that “in Australia, significant inequities exist between different population groups”. Compared with the other DHHS documents, this framework pays considerable attention to discussing the determinants of health and wellbeing. It states that “the DHHS recognises that the social contexts in which people live have a powerful influence on their health and wellbeing, as do physical factors and genetic predispositions; this view acknowledges that we should enhance the capabilities of individuals, families, communities and organisations to create and sustain health-promoting environments that enable people to make healthy choices and that reduce social and economic difficulties”. The framework also clearly identifies what it calls “structural determinants” of health (poverty, income, education, working conditions, employment, housing and area of residence, transport, community cohesion, discriminatory practices, physical environment). The document notes that to improve health and wellbeing there is a need to both reduce lifestyle and social risk factors and “enhance protective factors such as jobs, social inclusion, physical activity, and access to health and human services”.

The document also presents a picture of chronic conditions nationally and in Tasmania. It identifies the groups experiencing “major disadvantage” as including Aboriginal and Torres Strait Islander peoples, the socio-economically disadvantaged, rural and remote populations, and immigrant groups. It also notes that disadvantage may be experienced in relation to age and gender. One whole section explores “social and environmental influences on chronic conditions”, and sub-sections consider poverty, education and housing. Under “Poverty” it acknowledges, for example, that “the financially worst-off experience the highest rates of illness and premature death”. It also cites Tasmanian-based research which showed “Tasmanians reporting lower self-assessed health status as their financial capacity decreases”. Under “Employment” it says that “unemployed people experience a higher prevalence of disability [and] more serious chronic illness”, that “people with a disability experience an unemployment rate 65% higher than people without disabilities”. In terms of responsibility for health equity, this document acknowledges that the health and service system cannot address all determinants alone but that it can address risk factors, encourage self-management strategies, promote consumer education and improve access to care. It also notes the importance of including within the intervention processes a consideration of equity impacts and the potential impact of policies on disadvantaged groups.

The Aboriginal Health Plan identifies Aboriginal people as, in general, being the least healthy population group in Australia and says that Aboriginal people are “clearly disadvantaged” compared
with other Australians on “most key social and economic indicators”. It draws on the results of the 1998 Healthy Community Survey which indicated that “Tasmanian Aboriginal people experience disadvantage in areas such as welfare, education, employment, housing and access to services, all of which have an impact on their health and wellbeing. The document notes that health is a fundamental right for all, but that Aboriginal people “experience far greater inequities in terms of health and wellbeing status” and the document will help the DHHS to respond to these inequities in health and wellbeing.

The **Food & Nutrition Policy** and associated **Action and Monitoring Plan** take a whole-of-population approach to implementation but recognise that some groups are “more vulnerable to food insecurity” and may require additional targeting. It identifies these as people on low incomes, the unemployed, the homeless, young people, people paying rent or board, Aboriginal and Torres Strait Islander groups, refugees and other migrants. **LIVE LIFE Get Moving** similarly does not talk much about health inequities but does highlight the need to target those “more at risk of being inactive” and to develop programs specifically for these groups. The document highlights Tasmania’s ageing population and rural communities as key target groups. The **DHHS Annual Report 2004-05** talks about 12 strategic priorities around which DHHS planning is based but does not mention equity or health equity. However, it does talk of things which could improve health equity, such as the need to “strengthen primary health and community care”, “progress Aboriginal reconciliation”, “build community capacity” and “ensure affordable housing”.

### 4. HEALTH OUTCOMES AND HEALTH ACCESS

The Tasmanian documents aim to improve health outcomes for the whole population, improve physical access and transport to services, and improve health outcomes for those with the poorest health. They do not discuss the social gradient or more equitable distribution of funding resources.

**Tasmania Together 2020** and **Tasmania Together Review** include aim to improve the social determinants of health, stating that “Together we will make Tasmania an icon for the rest of the world by creating a proud and confident society where our people live in harmony and prosperity”. This includes a “reasonable standard of living”. Goals for the whole population include some which focus on health and social determinants in the wider social, economic and environmental context. For example, in relation to “Our Community”, goals include

- Ensure all Tasmanians have a *reasonable standard of living* with regard to food, shelter, transport, justice, education, communication, health and community services.
- To have a community where people *feel safe and are safe* in all aspects of their lives.
- Foster an *inclusive society* that acknowledges and respects our multicultural heritage, values diversity and treats everyone with compassion and respect.

In relation to “Our Economy”, one goal is to “increase job and meaningful work opportunities in Tasmania”. Some goals seek to measure improvements in social determinants of health, such as reducing the proportion of households with income below the OECD poverty line, based on the rationale that “it is unacceptable for any Tasmanian to live below the poverty line”. This policy also makes some mention of the need to improve physical access to services so that people have access to services no matter where they choose to live.
Whilst some goals have benchmarks to improve health outcomes, benchmark indicators do not always target the “disadvantaged” groups that the document talks about. For example the following goal for diabetes has an age indicator but no indicators that could show improved outcomes for disadvantaged groups more likely to experience diabetes, such Aboriginal Tasmanians:

**Benchmark 5.1.3 [HEALTHY LIFESTYLES - DIABETES]**

Goal 5  Develop an approach to health and wellbeing that focuses on preventing poor health and encouraging healthy lifestyles.

Standard 1  Improve Tasmanians’ health through promotion of a comprehensive approach to a healthy lifestyle

Indicator 1.3  Type 2 diabetes in over 25-year-olds

Rationale  If the instances of Type 2 diabetes decreases it will reflect improved lifestyle (e.g. fitness, diet and reduction in obesity.)

Similarly, the goals to improve Year 12 retention rates and Years 3 and 5 literacy rates are not set so that improvements for the lowest quintile groups can be monitored.

Tasmania has identified the prevention and management of chronic conditions as one of its major strategic priorities for 2005 to 2008 and the **Chronic Conditions Policy Framework** aims to improve overall population health outcomes, improve health for those with the poorest health, and reduce the gap between those with the best and worst health. Social justice is also cited as a health and wellbeing outcome in its framework model. The objectives and guiding principles of the framework include support and promotion for the use of evidence-based interventions and actions to:

- target efforts to reduce disparities in the impact of chronic conditions among different segments of the population
- focus on disadvantaged and special population groups having appropriate health services

The framework aims for a coordinated approach to primary prevention, secondary prevention, early detection, tertiary prevention, treatment and care. It has also modified the SNAP Framework for General Practice (SNAP: smoking, nutrition, alcohol and physical activity), to develop “SNAPPS” which recognises the need to add Psychological and Social factors. It identifies these as sense of control, social support networks, resilience, family environment and chronic stress, and states that they are “emerging as significant contributors to a range of social and health problems, including chronic disease” and that in particular “continuing anxiety, social isolation, insecurity, low self-esteem and lack of control over work and home life have been found to be risk factors that increase the chance of poor mental health and premature death”. To this extent, it notes the need to focus community attention on the increased importance of social capital as a determinant of health.

The **Aboriginal Health Plan** explicitly aims to improve the health outcomes of those with the poorest health, provide better access to services, and provide access to wider opportunities for health and wellbeing for all, particularly for disadvantaged groups. It aims to improve the understanding of health issues confronting Aboriginal populations. It focuses particularly on action on wider issues that will help achieve Goal 10 of Tasmania Together (“Acknowledge and respect the contribution that the Aboriginal community and its culture have made, and continue to make, to Tasmania and its identity”). Action is therefore to include “encouraging mutual recognition and respect between Aboriginal and non-Aboriginal people, increasing Aboriginal participation in decision-making,
protecting and conserving Aboriginal culture and heritage, and recognising the importance of Aboriginal land”. The Plan also aims to provide non-Aboriginal people with information to understand the health issues facing Aboriginal people.

The **Food & Nutrition Policy** aims to improve social, health, economic and environmental outcomes associated with food and nutrition, in particular reducing the burden of disease associated with poor diet. This includes improving population health, improving health outcomes for those with the poorest health, and providing access to wider opportunities for health and wellbeing (universal and targeted). It will encourage a population approach to improve the diet of the whole community, to address issues of access to adequate amounts of safe, nutritious and acceptable food (food security), and to specifically to reduce social, cultural, economic, geographic and physical barriers to food security. **LIVE LIFE Get Moving** aims for a whole-of-government and community approach to addressing physical activity levels but also aims to identify target population groups. It states an intention to develop appropriate interventions, policies and programs for these groups and to base them on community need. The **DHHS Annual Report 2004-05** highlights communities as a key factor in the social determinants of health, stating that “communities are where many of the determinants of health and wellbeing come together”. It reinforces the DHHS intention to focus efforts on “communities with higher unemployment, increased reliance on pensions and benefits, lower educational achievements and poorer health outcomes”.

## 5. STRATEGIES FOR ACTION: HEALTH

Some Tasmanian documents give examples of initiatives that should address the social determinants of health, such as the Health-Promoting Schools model, or they quantify increases in services that may benefit the disadvantaged. However, despite a general commitment to improve health and wellbeing for disadvantaged groups and areas, not all documents clarify whether disadvantaged groups/areas are targeted, and initiatives to address health inequity could be more clearly identified.

The **Chronic Conditions Policy Framework** draws on the principle of universal and targeted approaches and multilevel strategies in different settings to address health and wellbeing for the whole population and for groups that “experience health disparities”. It states that intervention planning should include consideration of the impact on equity. At the time of analysis action plans were to be developed within the DHHS as priority activities by external agencies, through partnership initiatives, and by key state committees. For example, the Diabetes Key Leaders Group was to coordinate development of a plan for improved prevention and management of diabetes. This Framework particularly states that “disadvantaged population groups” should be considered as high priority targets for initiatives developed under any action plans (including Aboriginal Tasmanians). However, the DHHS priorities for the initial implementation of the framework in 2004-07 focus more on disease and health and the SNAPPS areas, plus issues in self-management and mental health. They do however mention those experiencing family violence, the homeless, and people with diabetes.

The **Aboriginal Health Plan** aims to increase opportunities for workforce development for Aboriginal people through Aboriginal recruitment and career development, improve linkages across DHHS to better coordinate and manage access and services for Aboriginal people, and improve service responsiveness and effectiveness. The DHHS commits in this Plan to employ an Aboriginal Liaison Officer in each of the three major hospitals in Tasmania and develop a network of designated key contact officers within specific service areas to provide initial contact points for Aboriginal people and
organizations, and reference points for gathering information about how to improve services. The Plan contains one target in relation to health/disease which is to work for the best practice treatment and management of chronic conditions for Aboriginal people (diabetes/CVD/renal failure). It also contains a target to improve housing by reviewing the Aboriginal Housing Services Tasmania State Plan 2001-2002 and developing an ongoing program of implementation. Some targets are to implement existing plans rather than develop new programs or initiatives, with the target area of “Nutrition”, for example, aiming within 12 months to “identify and progress nutrition strategies appropriate for Aboriginal communities” and ensure consistency with the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan.

The Food & Nutrition Policy contains specific plans to address health inequity and identifies priority action areas. It mentions “interventions for the prevention of malnutrition for vulnerable groups” that could include programs to build skills and knowledge in food and nutrition, screening for nutritional problems within hospitals and institutions, and awareness-raising among health workers. The accompanying Action & Monitoring Plan identifies target groups as those disadvantaged in relation to food security. It includes measurable outcome indicators for these groups. Goal 5 is one example:

Outcomes (include): “Improved service delivery to those people experiencing physiological, cultural, social, geographical and economic barriers to accessing healthy and safe food.”

Sub-goals (include): “Reduce social, cultural and economic barriers to food security”

Objective: “To improve access to safe and nutritious food supply by individuals and groups with financial constraints affecting ability to purchase food.

Target group: People who may experience economic barriers to food, including homeless, low income, people with disabilities, mental illness and/or alcohol or other drug dependency, older people.

Strategies (include): Develop partnerships between welfare organisation, NGO, and governments to increase access and supply through targeted intervention schemes for those people who may be unable to afford safe and nutritious food, including Meals on Wheels, emergency food relief, low cost meals (such as City Mission meals), financial support (Centrelink), and subsidised meals (breakfast programs/school meals).

Other strategies under this goal target those from a non-English speaking background and those with low literacy levels.

LIVE LIFE Get Moving aims to generally increase physical activity levels within the population, for example through mass media campaigns. However, it includes some goals and strategies that aim to develop initiatives for those more at risk of being inactive (listed as women, older adults, middle aged adults, people of lower socioeconomic status and culturally and linguistically diverse groups, those in rural communities, older adults, children and adolescents). It also aims to target particular settings, such as schools and childcare, workplaces, the community, home, and primary care/GP locations. The Annual Report lists some initiatives outside of health that relate to social determinants of health, such as Housing Tasmania’s Affordable Housing Strategy which provides grants to community groups to
support urban renewal and capacity building activities. It noted that the AHS had been allocated additional funding from the Economic and Social Infrastructure Fund (ESIF) to implement capital development and assistance programs such as building new housing and upgrading existing housing, financial support for those in private rental, and financial support to encourage home ownership amongst low income earners.

**TARGETING CHILDREN & REFUGEES**

Several Tasmanian documents specifically mention children and migrants as requiring support, but do not necessarily address these groups in action plans or initiatives. For example, the Chronic Conditions Policy Framework notes that “intervening in early childhood is becoming increasingly recognised as important for influencing later life” and that families with children “...that are at risk of poverty, relationship breakdown, and abuse or inept parenting styles, for example, are more likely to produce teenagers at risk of criminality and substance abuse”. It correspondingly notes that “maximum health gain may be achieved through a focus on early childhood”. However, the document does not encourage attention to these issues in action plans. In contrast, the Aboriginal Plan does contain a target area covering children, families, and early childhood, with specific activities planned to “identify priorities for Aboriginal children and their families in relation to health and wellbeing”, to “develop specific Aboriginal health & wellbeing key indicators in Our Kids Action Plan 2004-07”, and to “undertake initiatives that improve cultural access to services”. The Food & Nutrition Policy targets early child health in two ways. Firstly, through endorsing breastfeeding as the preferred method of infant feeding, and secondly through targeting child-related settings (eg pre-school and family). Initiatives targeting children also address obesity, and there are specific outcome-related goals to “increase the percentage of infants breastfed on post-natal discharge from maternity services” and to “increase the percentage of infants exclusively and partially breastfed to six months of age”.

Refugees are not mentioned specifically in Tasmanian initiatives, but this is perhaps not surprising considering the relatively small number who currently arrive in Tasmania. However, they could be construed as included under the broader categories of “migrant” and “non-English speaking background”. The Chronic Conditions Policy Framework includes migrants in the group who currently experiences “major disadvantage”, but does not specifically identify refugees. The Food & Nutrition Policy has interventions targeting migrant groups for increased access to healthy foods, increased experience of unfamiliar foods and eating practices, and affirming and re-establishing traditional practices that can prevent the development of lifestyle related diseases. The policy identifies potential partners in this intervention as including migrant services and NGOs.

6. **STRATEGIES FOR ACTION: OTHERS INVOLVED**

Most documents talk of the need for collaboration on initiatives and the need for community input if planning is to be effective. Tasmania Together 2020 and its Review are presented as being owned by all Tasmanians. They talk of working “as a community to make Tasmania a better place” and suggest that improvements can be made by everyone including individuals, organisations, the business and community sector, the State Government or Local Government. The Chronic Conditions Policy Framework similarly presents itself as community-owned and talks of the DHHS needing to work in partnership with other organisations and sectors, other government agencies, non-government organisations, and the community sector, if the required systemic and sustainable changes are to be achieved in addressing chronic health conditions. It talks of the need to advocate for and foster whole-of-system and partnership approaches to the prevention and management of chronic conditions. The
document also highlights the need for a coordinated approach with evidence-based decision-making processes, and “targeted efforts to reduce disparities” in the impact of chronic conditions between different segments of the population. The document also notes that international and national strategies are now moving towards a clustered approach which recognises common causal pathways for many complex chronic conditions, so that responses will also need to be integrated and multifaceted.

The Aboriginal Health Plan has two specific targets for including others in actions to improve health outcomes for Aboriginal people. These are to strengthen inter-Agency and inter-Government joint planning, and to improve co-ordination and collaboration with other Agencies addressing Aboriginal issues, specifically in relation to reducing fragmentation and duplication. The document says that in this approach it is consistent with the Council of Australian Government’s (COAG) Reconciliation Framework (2000) that advocates a whole of Government approach in addressing three priority areas. The document also states the DHHS acknowledgement that the continued involvement of Aboriginal communities in the plan is critical to its success, because many of the past approaches which have been ad hoc and imposed from outside Aboriginal communities have resulted in poorly planned and unsustainable programs that have also sometimes led to a loss of culture, networks and knowledge. This plan therefore includes strategies to enable Aboriginal people to participate in the planning, design and implementation of programs that have an impact upon their health. In endorsing the broad goals of Tasmania Together, The Food & Nutrition Policy’s Action & Monitoring Plan also states that a collaborative approach will be needed for most strategies and identifies potential partners for each sub-goal. These include government departments, private organisations, professional associations, industry, the non-government and community sectors, as well as workforce development.

7. IMPLEMENTATION

Some documents give examples of initiatives addressing social determinants of health, but not all clarify whether disadvantaged groups/areas are targeted, and quantitative indicators to measure improvement for these groups/areas are not always included. Discussion of funding is patchy.

The Tasmania Together Review provides community feedback which suggests that there has been some improvement in some social determinants of health (although it is not clear whether this has in any way resulted from government initiatives aimed at such improvements). For example, the document states that people “talked about more jobs, better house prices, improvements in crime statistics, a healthier environment and a general feeling of confidence. They praised changes in smoking and relationship laws, more variety in food and shopping, and the increase in tourists sharing an appreciation of Tasmania”. The Chronic Conditions Policy Framework gives examples of supportive school environments with programs to develop sense of belonging, social support, and individual resilience by way of the Health-Promoting Schools model and the Mind Matters mental health promotion project. However, there is no evidence of whether these programs are targeted to areas or groups with higher levels of health need. There is also little mention of funding, except to say that the available financial resources will be “judiciously” allocated to strategies that will reduce the cost to the community of chronic conditions.

The Aboriginal Health Plan does not contain evidence of being implemented, but states that annual work plans will be developed by DHHS to prioritise and provide further detail about initiatives, including annual resource allocation towards implementing the plan. The Food & Nutrition Policy also does not provide evidence that it has been implemented. However, it uses existing or earlier initiatives as examples, such as an Eating with Friends program. It also talks of specifically using this
to “increase opportunities for socially isolated and older Tasmanians to eat together through wider implementation of the Eating with Friends program or other similar strategies”, and talks of using the Cooking for One program to develop and implement programs that develop skills in nutrition, food preparation and handling for those people who are socially isolated. It does not mention funding allocation, but does acknowledge that to be effective such programs need sustained, ongoing funding and to be fully implemented before their success, or otherwise, can be appropriately determined. **LIVE LIFE Get Moving** talks of funding commitment, mentioning that the Government has committed over $25 million towards physical activity in the form of new gymnasiums, new equipment and upgrading play and sporting facilities in schools state-wide. Its 4th goal is to “identify and commit appropriate levels of dedicated funding to address the long term needs of physical activity in Tasmania”.

The DHHS **Annual Report** provides the most comprehensive listing of initiatives that can be considered as addressing health equity issues, although it gives little information about funding allocation. It talks, for example, of the illegal sale of cigarettes to children having been significantly reduced between a 2002 and 2004 survey (with only 5% of Tasmanian tobacco retailers selling cigarettes to children compared to 48% in 2002). It also notes Housing Tasmania’s support for a wide range of community capacity building activities such as working with at-risk students from primary schools at the Shorewell Community Garden; establishing a residents’ community room at Stainforth Court in partnership with Community Services students from TAFE; and providing tools for a Community Tool Shed in Bridgewater. It also talks of the need to establish the East Devonport Neighbourhood house and provide $600,000 through the Community Support Levy for the development of community capacity programs within Neighbourhood Houses across Tasmania. Under “Emerging Issues” the Report highlights the need for some targeted programs, for example to address the steady and substantial increase in males aged 25-44 completing suicide, including in custodial settings.

8. **EVALUATION**

Some documents have strategies, goals and objectives clearly linked to measurable targets and benchmarks. However, improving data collection and improving the monitoring and evaluation of priorities and change in health indicators is still a future objective for most documents. It would be beneficial if these steps were to include the incorporation of indicators that could allow measurement of improvements in health outcomes and access for the disadvantaged groups/areas mentioned.

Although **Tasmania Together 2020** and its Review are only guiding documents, the Board states an intention to develop new measures in areas relevant to social determinants of health and to disadvantaged groups (including new measures in relation to community connection and families, people with disabilities and their participation in the community, ageing and associated issues of independent living, work and health, housing costs and availability, health waiting times, mental health and obesity). The Review shows some evidence that the Board is responding to changing circumstances for some disadvantaged groups, for example in responding to the impact on transport availability and cost of petrol price rises for people in rural communities. Although the document does not use health inequities language, it does have some clear targets and benchmarks which address social determinants of health and specific benchmarks at 5-yearly intervals (2010, 2015, 2020) to achieve each of its 23 goals. For example, in relation to the “Our Community” goal, benchmark 1.1.2 specifically aims to improve outcomes for those on low incomes:
Our Community

Benchmark 1.1.2

Goal 1 Ensure all Tasmanians have a reasonable standard of living with regard to food, shelter, transport, justice, education, communication, health and community services.

Standard 1 To ensure that all Tasmanians have the economic capacity to enjoy a reasonable standard of living and access to basic services.

Indicator 1.2 Proportion of households with income below the OECD poverty line

Jul 99-Jun 00: 10% of Tasmanian income units less than OECD poverty line (A$415.00 per week) (ABS 6523 - OECD poverty line)

Targets 2005: 8%
2010: 6%
2015: 4%
2020: 0%

Rationale It is unacceptable for any Tasmanian to live below the poverty line.

Tasmania Together has a clear process for monitoring and evaluating progress against these benchmarks through the Tasmania Together Review process conducted every 5 years (and for the first time in 2005). When reviews are conducted, benchmarks are revised where appropriate. A community consultation process is part of each review to elicit input to the next iteration of the plan. The Board notes that progress cannot be reported on yet in some areas because appropriate measures still have to be identified.

The Chronic Conditions Policy Framework does not contain any clear measurable targets or deadlines to achieve its intended outcomes, but does highlight where data is lacking on the incidence and impact of chronic conditions. It calls for the action plans to include efforts to improve data collection and reporting. The Framework states that “evaluation of the outcomes of this policy framework against its stated objectives will involve both qualitative and quantitative review” and that quantitative analysis will require surveillance of risk factors and disease burdens; qualitative review will focus on health and human service improvement and improved quality of life for individuals. It says that key indicators for the evaluation of health services are health improvement, fair access, delivery of appropriate healthcare, efficiency, patient/carer experience and reduced levels of risk factors and disease. The Framework states that a number of current and planned epidemiological reporting processes are to be used to improve the monitoring and surveillance of health and wellbeing indicators, including the State of Public Health Report, the Healthy Communities Survey and the Tasmania Together indicators. The DHHS Agency Executive Committee is allocated responsibility to oversee the monitoring, evaluation and review of the policies implemented in relation to the Department’s strategic priorities, and this is to include a comprehensive analysis of changes in health indicators and improvement of the effectiveness of the health and human service system in the prevention and management of chronic conditions. Since the Framework itself talks of health “differences” between different population groups and identifies those experiencing major disadvantage, it would be hoped that such data collection would enable the reporting of progress in relation to measured reductions in health inequities between these groups. The Framework stands out amongst the majority of health department documents assessed for Australia in mentioning the need for “health and wellbeing impact assessment of macro social and economic policy” (ie some societal determinants of health), although the pathways to achieve this are not discussed.
The DHHS has identified as a major project for the Aboriginal Health Plan the development of an Information Development Strategy to enable the collection of appropriate information on the health needs and service utilisation of Aboriginal people. The Plan says that this project arose because Tasmania had great difficulty reporting against the national performance indicators required in 1996 by AHMAC of all Heads of Aboriginal Health Units. The Plan explains that difficulties have resulted for a number of reasons, including reluctance to identify as Aboriginal and poor data systems and analysis. Improvement of health indicator data collection and reporting will assist the reporting against Tasmania Together Goal 10 indicators. Progress against the Plan was to be reported in the DHHS Annual Report. LIVE LIFE Get Moving has as part of Goal 4 to “Implement and monitor progress of the Tasmanian Physical Activity Plan”, but says little more than this. By contrast, the Food & Nutrition Policy and associated Action and Monitoring Plan aim to address the goals and sub-goals of the Tasmanian Food and Nutrition Policy. They state that attempts have been made to align outcome indicators with those of other key policies such as Tasmania Together, State of Growth and Eat Well Australia to improve efficiency and reduce reporting burden on lead Agencies. The Plan contains objectives against the Policy’s goals and sub-goals, with suggested strategies, process indicators and impact indicators to aid implementation. A series of outcome indicators are also identified to assist the monitoring of progress towards achieving the Policy’s goals, although outcome indicators for some goals were still to be developed. The Policy and Plan acknowledge that comprehensive monitoring of nutritional intake and nutritional status is costly and requires a high level of expertise, and that it is unlikely Tasmania will have sufficient expertise or finances to support effective monitoring at a state level. It therefore calls for Tasmania to continue advocating for effective national nutrition monitoring systems. Nevertheless, the Policy commits to a 4-yearly report from its Steering Committee to the Tasmanian Government outlining actions taken to address the Policy goals and sub-goals.

The DHHS Annual Report retrospectively describes selected achievements under each of the DHHS’ 12 strategic priorities, but this does not necessarily include health equity issues. For example, although under reporting for the strategy “Strengthening and Prevention and Management of Chronic Conditions” it says that the DHHS is “currently involved in a broad range of activities designed to address chronic conditions”, it does not say whether these are targeted to areas or people with greater burden of chronic conditions such as the socially disadvantaged. It does however note that the chronic disease burden is increasing with the ageing population. The Annual Report also refers to the Tasmania Together Review targets, benchmarks and achievements.

B. KEY DOCUMENTS USED FOR THIS ANALYSIS

Recommended by Ms Victoria Rigney, Manager, Policy Unit, Strategic Policy & Planning Unit, Community Population & Rural Health, Tasmanian Dept of Health & Human Services

Tasmania Together Progress Board

Department of Health & Human Services

www.dhhs.tas.gov.au


(2005) *Aboriginal Health & Wellbeing Strategic Plan*  
http://www.dhhs.tas.gov.au/agency/pro/aboriginalhealth/

The Premier’s Physical Activity Council

www.physicalactivity.tas.gov.au

**Also referred to**

Department of Health & Human Services *Annual Report 2004-05*  