Foundation for Alcohol Research & Education

FARE's submission to the Senate Inquiry into: Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"

About the Foundation for Alcohol Research and Education

The Foundation for Alcohol Research and Education (FARE) is an independent charitable organisation working to prevent the harmful use of alcohol in Australia. Our mission is to help Australia change the way it drinks by:

- helping communities to prevent and reduce alcohol-related harms;
- building the case for alcohol policy reform; and
- engaging Australians in conversations about our drinking culture.

Over the last ten years FARE has have invested more than $115 million, helped 800 organisations and funded over 1,500 projects addressing the harms caused by alcohol misuse.

FARE is guided by the World Health Organization's *Global Strategy to Reduce the Harmful Use of Alcohol*[i] for addressing alcohol-related harms through population-based strategies, problem-directed policies, and direct interventions.

If you would like to contribute to FARE's important work, call us on (02) 6122 8600 or email fare@fare.org.au. All donations to FARE over $2 are tax deductible.

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[i] World Health Organization (2010). *Global strategy to reduce the harmful use of alcohol.* Geneva: World Health Organization.

Contents

Acronyms

ABS:	Australian Bureau of Statistics
Action plan:	*Action plan for the global strategy for the prevention and control of non-communicable diseases (NCD)s for 2013-2020*
AIHW:	Australian Institute of Health and Welfare
ANPHA:	Australia's National Preventative Health Agency (ANPHA)
APC:	Alcohol per capita consumption
COAG:	Council of Australian Governments
DoHA:	Commonwealth Government Department of Health and Ageing
FARE:	Foundation for Alcohol Research and Education
FASD:	Fetal Alcohol Spectrum Disorders
Global strategy:	*Global strategy to reduce the harmful use of alcohol*'
Global monitoring framework:	*Global monitoring framework and targets for the prevention and control of NCDs*
NADK:	National Alcohol Data Knowledgebase
NCETA:	National Centre on Education and Training on Addiction
NDARC:	National Drug and Alcohol Research Centre
NDRI:	National Drug Research Institute
NDSHS:	National Drug Strategy Household Survey
NHMRC Guidelines:	National Health and Medical Research Council Australian guidelines to reduce health risks from drinking alcohol
NCDs:	Non communicable diseases
UN:	United Nations
VAGO:	Victorian Auditor General's Office
VYADS:	Victorian Youth Alcohol and Drug Survey
WET:	Wine Equalisation Tax
WHO:	World Health Organization

Introduction

Over the last decade our understanding of the factors that contribute to positive health and life outcomes have improved significantly. This has culminated in the development of the World Health Organization (WHO) Commission on Social Determinants of Health in 2005.

Put simply the social determinants of health are the circumstances in which people are born, live, work and grow that contribute to their health. These circumstances often fall outside of the traditional health portfolio and have a great impact on the inequities that exist between countries, within countries and even within local communities.

The social determinants of health are relevant to alcohol policy because the way that people consume alcohol is influenced upon a range of life circumstances. These include people's age, gender, cultural background and place of residence. This is why particular population groups within the broader Australian population experience disproportionate amounts of alcohol-related harms when compared to the rest of the population; these include young people and Aboriginal and Torres Strait Islander peoples.

Alcohol can be both a consequence of and contributor to poor health and inequity.[1] For example, harmful alcohol consumption can be as a result of poor living conditions and lack of employment, and can also lead to these circumstances as well (loss of housing or employment), due to alcohol-related problems.

In Australia alcohol accounts for 3.2% of the total burden of disease and injury each year, 3,430 deaths and a loss of 85,435 disability adjusted life years.[2] Alcohol consumption also impacts on people around the drinker. In 2005, someone else's drinking resulted in 367 deaths, 14,000 hospitalisations and 70,000 cases of alcohol related violence, including 24,000 cases of domestic violence. In 2006-07 almost 20,000 children were victims of substantiated alcohol-related child abuse.[3]

Understanding the different factors that contribute to risky alcohol consumption and alcohol-related harms allows Governments to develop policies that specifically target these factors, therefore contributing to a reduction in harms.

However, it is not enough to simply understand the social determinants of health. Governments at all levels must also develop mechanisms that allow for this understanding to be applied to all public policy development, including asking the question of whether policies will detrimentally impact on a person's poor health or indeed poorer health outcomes. This should include working collaboratively with other countries in developing, implementing and evaluating global frameworks which support shared, comprehensive and multi-sectoral action to prevent significant harms that result from alcohol consumption.

It is vital that the Commonwealth Government commits to actions to reduce alcohol-related harms in Australia. This should be done by developing a new National Alcohol Strategy which recognises the social determinants approach to health and outlines the coordinated and planned strategies across Government portfolios to reduce alcohol-related harms. The strategy should also recognise that the most effective solutions to reduce alcohol-related harms are population-based strategies that seek to address the price, promotion and availability of alcohol. These measures are cost-effective, and have been recommended by countless reviews including the Preventative Health Taskforce.[4,5]

Structure of the Submission

The Foundation for Alcohol Research and Education (FARE) welcomes the opportunity to provide this submission to the Senate Inquiry into *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report 'Closing the gap within a generation'*.

Within this submission FARE has addressed each of the Terms of Reference of the Inquiry, which are:

a) Government's response to other relevant WHO reports and declarations;
b) impacts of the Government's response;
c) extent to which the Commonwealth is adopting a social determinants of health approach through:
   (i) relevant Commonwealth programs and services,
   (ii) the structures and activities of national health agencies, and
   (iii) appropriate Commonwealth data gathering and analysis; and
d) scope for improving awareness of social determinants of health:
   (i) in the community,
   (ii) within government programs, and
   (i) amongst health and community service providers.

Recommendations

Recommendation 1: *That the Commonwealth Government develops and implements a new National Alcohol Strategy that is informed by the 'Global strategy to reduce the harmful use of alcohol'.*

Recommendation 2: *That the Commonwealth Government supports the inclusion of a target for a ten per cent relative reduction in persons aged 15+ alcohol per capita consumption (APC) in the 'Global monitoring framework and targets for the prevention and control of Non Communicable Diseases'(NCDs).*

Recommendation 3: *That the Commonwealth Government adopts a social determinants of health approach in addressing fetal alcohol spectrum disorders (FASD) and implement the actions outlined in the 'Foundation for Alcohol Research and Education's Australian FASD Action Plan 2013-2016'.*

Recommendation 4: *That the Commonwealth Government continues to provide funding for the Australian National Preventive Health Agency to coordinate policy development and programs to prevent alcohol-related harms.*

Recommendation 5: *That the Commonwealth Government develops a national data repository for alcohol-related harms.*

Recommendation 6: *That the South Australian, Victorian, Tasmanian and New South Wales Governments recommence the collection of alcohol sales data to better inform alcohol policy.*

Recommendation 7: *That the National Perinatal Minimum Dataset includes standardised questions about alcohol consumption during pregnancy.*

Recommendation 8: *That the Commonwealth Government adopts a 'health in all policies' approach to public policy development which includes the establishment of health benchmarks and monitoring structures to ensure cross government action is being implemented and targets achieved.*

Reponses to the terms of reference

(a) Government's response to other relevant WHO reports and declarations

The Government's response to alcohol-related WHO reports and declarations has been inadequate. This is demonstrated by Australia's response in two areas: first to the *Global strategy to reduce the harmful use of alcohol*, and second to the *Global Monitoring framework and targets for the prevention and control of Non Communicable Diseases* (NCDs).

1. Australia's response to the Global strategy to reduce the harmful use of alcohol

The release of the *Global strategy to reduce the harmful use of alcohol* (hereafter called the *Global strategy*) in 2010 was endorsed by the World Health Assembly (representing all 193 WHO Member States).[6] The priorities in the strategy include reducing the availability of alcohol, reducing the impact of alcohol marketing and implementing changes to domestic taxation systems to influence the price of alcohol.[6] All of the priorities in the *Global strategy* reflect current international evidence on effective interventions to reduce alcohol-related harms.[7]

The *Global strategy* warns that "preventing and reducing harmful use of alcohol is often given a low priority among decision-makers despite compelling evidence of its serious public health effects".[6] This certainly appears to be the case in Australia where the national policy response remains noticeably absent from Commonwealth Government and State and Territory Government agendas.

The *Global strategy* urged countries to strengthen their own national responses to the harmful use of alcohol. Despite this, the Australian Government does not have a national alcohol strategy, as the *National Alcohol Strategy 2006-2011* has expired. The strategy was extended from 2009 to 2011 but has not been updated since.[8]

The lack of strategy is resulting in limited effectiveness of Government efforts.[9] A recent report by the Victorian Auditor General's Office (VAGO) on alcohol-related harms found that while various individual measures to address alcohol-related harms have been introduced, these are fragmented in design and implementation.[9] This is because initiatives are not part of a strategy and so not assured as being the most cost effective or efficient use of resources. This is concerning as it reflects the current national situation where there is no national alcohol strategy.

Australia now needs to develop a new National Alcohol Strategy that takes into account the policy areas contained in the *Global strategy*. The Strategy should include strong leadership on policies to reduce the availability and marketing of alcohol and implement changes to the alcohol taxation systems as recommended in the *National Preventative Health Strategy*[5] and the Henry Tax Review.[10]

Recommendation 1: *That the Commonwealth Government develops and implements a new National Alcohol Strategy that is informed by the 'Global strategy to reduce the harmful use of alcohol'.*

2. Australia's response to the Global monitoring framework and targets for the prevention and control of NCDs

In 2011 WHO commenced the development of *A Global monitoring framework and targets for the prevention and control of non-communicable diseases (NCDs) (Global monitoring framework)*. NCDs are the leading global cause of death worldwide and are primarily comprised of cardiovascular diseases, cancers, diabetes and chronic respiratory diseases.[11] A large proportion of these NCDs are preventable as they share common modifiable risk factors which includes tobacco use, unhealthy diet, lack of physical activity and the harmful use of alcohol.[11]

As a member of the World Health Assembly, the Australian Government, through the Commonwealth Department of Health and Ageing (DoHA), has made submissions on the development of the *Global monitoring framework* over the course of 2012.

The consultation on the first version of the WHO discussion paper on the *Global monitoring framework* took place between 20 December 2011 and 29 February 2012. This discussion paper outlined ten global targets for diabetes, tobacco smoking, alcohol, dietary issues (such as salt intake) and cervical cancer screening. The proposed alcohol target was a "10% relative reduction in persons aged 15+ alcohol per capita consumption (APC)".[11]

Australia's submission (dated 29 February 2012) in response to the proposed alcohol target stated that it was "unlikely" that Australia would meet this target by 2020 (against a baseline in 2010[12]), with the reason given that "Australia's current APC is relatively stable and not expected to significantly decline".[13]

Australia's response is extremely disappointing and is also more negative than any of Australia's responses to the other proposed targets. Alcohol is the only target in which the Commonwealth Government has "significant concerns" about. A proposed ten per cent reduction in the prevalence of diabetes, for example, was accepted as "possible" by the Commonwealth Government, despite rates of diabetes in Australia currently increasing.

Australia's response to the proposed alcohol target goes against the current evidence that shows reducing the overall level of alcohol consumption is the most effective strategy to reduce the risk of most alcohol-attributable health conditions.[6,7] Australia's response also ignores the fact that WHO targets are based upon a critical assessment of the evidence and that the feasibility of these being achieved has been based on the current achievements of the member countries. WHO substantiated this by showing that "between 1990-2005, 46 countries decreased their APC including Argentina, Canada, Chile, France, Italy, New Zealand and Switzerland".[14]

Efforts to reduce the overall per capita consumption of alcohol should be at the core of Australia's efforts to reduce alcohol-related harm. By not supporting this target, the Commonwealth Government has demonstrated that they are not committed to taking action to reduce alcohol-related harm now or in the future.

Recommendation 2: *That the Commonwealth Government supports the inclusion of a target for a ten per cent relative reduction in persons aged 15+ alcohol per capita consumption (APC) in the 'Global monitoring framework and targets for the prevention and control of Non Communicable Diseases'(NCDs).*

(b) impacts of the Government's response

Australian governments' responses to alcohol have largely not considered the broader influences in people's lives that contribute to alcohol consumption and alcohol-related harm. As a consequence, overall population-wide alcohol consumption levels and alcohol-related harms continue to remain at unacceptable levels or are increasing. Key measures show that:

1. Overall per capita consumption of alcohol has remained stable since 2006 (with marginal declines in 2010-11)
2. Heavy binge drinking (20+ standard drinks in once occasion) by young people is increasing, and
3. Harms due to alcohol are increasing.

Until the Government adopts population-based measures little will change.

1. Overall per capita consumption of alcohol has remained stable since 2006

Estimates on the Australian APC by Australians is collected by the Australian Bureau of Statistics (ABS) and published in the 'estimates of apparent consumption'. Apparent consumption data are derived using information relating to supply (i.e., data on domestic sales of Australian produced wine, excise data on alcohol produced for domestic consumption, data on imports and an estimated component for home production), as opposed to sales data, and only provide a measure of the alcohol i.e. available for consumption in a given financial year.

In 2009 the National Drug Research Institute's (NDRI) report into National Alcohol Sales Data stated that "the importance of alcohol consumption as an indicator of community alcohol use and harm can hardly be overstated".[15] NDRI outlines the strong relationship between APC and alcohol-related harms including road accidents, falls and other accidents, illness, assault and other alcohol-related crime and the importance of collecting this data.[15] APC is vital to understanding trends in the extent and patterns of consumption, as well as the alcohol content of products being consumed across the population.

The estimates of consumption over time show that APC has fluctuated peaking at 13.1 litres of pure alcohol per person in 1974-75 and declining to 9.8 litres in 1996-95. Since the mid-1990s consumption has gradually increased to 10.6 litres in 2006, remaining stable to 2008 and with a slight decrease to 10.0 litres in 2010-11.[16] This is more than two standard drinks per person per day and is in excess of the National Health and Medical Research Council (NHRMC) recommended guidelines for long-term harm.[17]

At 10.0 litres of pure alcohol per person over 15 years, Australia's per capita alcohol consumption is high by world standards. A WHO report released in 2011 tilted the '*Global status report on alcohol and health*' showed that in 2005 the worldwide per capita consumption of alcohol was 6.13 litres of pure alcohol per person (aged 15 years or older).[18]

2. Heavy binge drinking (20+ standard drinks in one occasion) by young people is increasing

Recent alcohol consumption data from Victoria highlight that people's patterns of alcohol consumption are changing with more extreme drinking behaviours are becoming the norm.

Data from the Victorian Youth Alcohol and Drug Survey (VYADS) published in 2010 found that young people's drinking behaviour is changing. Of people aged 16 to24 years old, two-fifths (42 per cent) engaged in high-level drinking, having drunk 20 or more standard drinks on at least one day, in the past year. The number of young people doing this had increased by 16 per cent since 2002. The trend was evident across all ages but more marked among young women than men.[19] This "extreme binge drinking" is contributing to an increase in alcohol-related harms.

3. Harms due to alcohol consumption are increasing

The National Alcohol Indicator Project, undertaken by NDRI, found that between 1996 and 2005 the rates of alcohol-attributable hospitalisations increased by more than 30 per cent.[20]

More recent data from a report published by the Victorian Auditor General's Office (VAGO) demonstrates the changes in patterns of alcohol consumption and the resultant harms. VAGO compared alcohol harms from 2000-01 to 2010-11 and showed that:

- emergency department presentations for intoxication increased by 93 per cent
- people hospitalised for alcohol intoxication increased by 87 per cent
- hospitalisations for alcohol-related assault increased by 22 per cent, and
- during the six year period that the Victorian Alcohol Action Plan 2008–13 was being developed, the number of licenced premises increased by 52 per cent.[9,20]

While this data is specific to Victoria, there is no reason to suggest that the trend in increasing alcohol-related harms is not occurring throughout Australia.

(c) extent to which the Commonwealth is adopting a social determinants of health approach

WHO recommends that in order to reduce alcohol-related harm the Government must goes beyond the traditional boundaries of health portfolios and implement population measures that have the prevention of harm at their centre. This is because a person's alcohol consumption is affected by where they live, their income, education, occupation, gender and race/ethnicity.[21]

WHO warns that population-wide actions are likely to be under constant attack and met with resistance to implementation.[22] An example of a population wide measure that is being met with resistance is Alcohol Management Plans (AMPs). AMPs typically involve a collection of initiatives aimed reducing the supply and demand of alcohol and therefore aiming to reduce alcohol-harms in the community. AMPs have been found to be effective in reducing alcohol-related injuries, including serious injury.[23] Despite this The Northern Territory and Queensland Governments have indicated that they are reviewing these measures, with a view to relaxing or removing these measures.[24]

The Queensland Government is also cutting $4.4 million in funding to the prevention services across the state including funding of alcohol and drug prevention workers, nutrition promotion and healthy lifestyle programs.[25] Reflecting on these cuts Family Planning Queensland said "what these grants

represent is cuts to most of the preventative work, the work that helps us prevent people needing to go to hospital and access more clinical services."[25]

The *Global Strategy* recommends that whole-of-government approach and population wide measures are required to reduce alcohol-related harm. This includes long term political commitment, effective coordination and sustainable funding are all essential. These can be difficult commitments for governments to make and can be challenging for Governments, as it requires them to work across portfolio areas. There are some areas where the Commonwealth Government has starting to adopt this approach. However, significant gaps still exist, particularly when cross portfolio and cross jurisdictional approaches are required to prevent alcohol-related harms.

(i) relevant Commonwealth programs and services

The Commonwealth Government has begun to demonstrate its understanding of the social determinants approach to health in Australia's own '*Closing the Gap*' Strategy.

The health and life expectancy of Aboriginal and Torres Strait Islander people is 12 years lower for men and ten years lower for women than the non-Indigenous population.[26] In November 2008 the Council of Australian Governments (COAG) agreed to a National Partnership Agreement of $1.6 billion to close the life expectancy gap between Indigenous and non-Indigenous Australians within a generation. This has become known as the '*Closing the Gap'* Strategy.

'*Closing the Gap*' is beginning to see the overall mortality rates for Indigenous Australians start to decline. In addition there has been a 64 per cent increase in the number of health assessments undertaken in 2009-10 from 2010-11. Tobacco coordinators and Healthy Lifestyle workers (162 positions) have also been appointed to work with Indigenous communities to reduce the lifestyle-risk factors that contribute to preventable chronic disease.[27] This Strategy demonstrates the success of initiatives which take a whole-of-life approach to policy and also demonstrate the strength of partnerships between Government, not-for-profit organisations and affected communities.

However, there are also areas where a social determinant approach is needed but is not being adopted. An example of this is the Commonwealth Government's response to Fetal Alcohol Spectrum Disorders (FASD).

FASD is a lifelong disability that is preventable and requires a whole-of-government response. FASD is an issue that crosses government departments, because people with FASD experience mental health issues, alcohol and drug problems, disrupted school experience and involvement with the criminal justice system. In addition, due to the underlying cognitive disability, people with FASD experience problems with day-to-day living, such as managing money and sustaining regular employment. As a result, the majority of adults with FASD may not be able to live independently.[28]

However, FASD can be prevented. Fundamental to this prevention is the reduction of harmful consumption of alcohol by the general population, and in particular by women during pregnancy. Prevention activities need to target the whole population to raise awareness of the potential risks associated with alcohol consumption during pregnancy and create a supportive environment for women who are pregnant or planning pregnancy to be alcohol-free during this time. This should be done through public education campaigns and mandatory health warning labels on all alcohol products. In addition, targeted prevention initiatives are needed to support women most at-risk of having a child or children with FASD. It is also imperative that all health professionals are able to ask

and advise women about their alcohol consumption at any stage of their lives. FASD is a good example of where adopting a social determinants approach to health would result in a reduction in the number of new cases and help support those who are affected.

Recommendation 3: *That the Commonwealth Government adopts a social determinants of health approach in addressing fetal alcohol spectrum disorders (FASD) and implement the actions outlined in the 'Foundation for Alcohol Research and Education's Australian FASD Action Plan 2013-2016'.*

(ii) the structures and activities of national health agencies

Implementing a social determinants of health approach requires a whole of government commitment to embedding these principles at every level and in every department. Unfortunately much of the current approach by the Commonwealth Government to address alcohol has been focused on individual behaviour change. Furthermore, departments have worked in siloes, seemingly incapable of working collaboratively with other departments.

For example when asked a question on the Wine Equalisation Tax (WET) and its effects on alcohol consumption during the Community Affairs Senate Estimate hearing in February 2012, the Secretary of DoHA responded: "I suspect you are in an area which is somewhere in between us and the Treasury. " She went on to say: "obviously, we can talk to you about the more general issue of the effect of taxation on consumption of various things—price signals et cetera. But in terms of the specifics of the wine equalisation tax, I am pleased to report that that is not my business."[29]

This highlight the considerable 'buck passing' between Commonwealth Departments to take any real action to change Australia's alcohol taxation system. This is despite the *2010 Henry Review* finding Australia's current alcohol taxation system to incoherent and inconsistent[10] and the growing body of evidence that one of the most effective policies to reduce alcohol-related harm is increasing the price of alcohol through taxation.[7]

The Commonwealth Government's establishment of Australia's National Preventative Health Agency (ANPHA) should be commended and is the most significant investment that the Government has made to reducing alcohol-related harm in recent years. ANPHA has helped to elevate prevention as a key strategy within the national health agenda. ANPHA, as a national organisation is in a unique position to address social determinants of health by driving the promotion of "Health in All Policies" approach across government departments and levels. This would require ANPHA to shift its focus from campaigns encouraging individual behaviour change, to adopting and advocating policy options that promote population-based measures and address the social determinants of health. ANPHA's public consultation and consideration of a Minimum (floor) Price for alcohol is a good example of how the Commonwealth Government is beginning to investigate these approaches.

Recommendation 4: *That the Commonwealth Government continues to provide funding for the Australian National Preventive Health Agency to coordinate policy development and programs to prevent alcohol-related harms.*

(iii) appropriate Commonwealth data gathering and analysis

The Commonwealth Government collects a variety of data on alcohol consumption in Australia including national surveys, alcohol industry sales data, hospital morbidity and mortality data, and alcohol-related road fatalities and injuries data. The longest running data collection on patterns and levels of alcohol consumption by Australian is the National Drug Strategy Household Survey (NDSHS) which has been undertaken every three years since 1985 by the Australian Institute of Health and Welfare (AIHW).

WHO has recognised that the monitoring of data is pivotal in being able to implement effective alcohol policies.[30] Unfortunately there are significant gaps in Australia's collection and monitoring of alcohol data. In 2011 a project undertaken by the National Centre on Education and Training on Addiction (NCETA) called the National Alcohol Data Knowledgebase (NADK) found that no single repository of alcohol-related data in Australia exists. NADK also found that there is no electronic database or directory of alcohol-related datasets. While a range of sectors collect data related to alcohol (including health, social welfare, law enforcement and education):

- this data is difficult to locate, access, and utilise
- there are no nationally agreed measures for collecting such data, and
- there is little coordination of data collection across jurisdictions. [31]

For example no standardised data is collected on alcohol consumption during pregnancy, or data on the number of people diagnosed with FASD. Without these key pieces of information it is not possible to know the true extent of FASD within the community or provide the appropriate levels of service for people with FASD and their families and carers.[32] Similarly, there is a lack of national data on incidents of driving under the influence, alcohol-related traffic accidents and national data is available on cider consumption or sales.

In addition, states and territories are not required to collect alcohol sales data. Until 1996, the apparent consumption data collected by the ABS was complemented by alcohol sales data provided by state and territory liquor licensing authorities. This information is still collected in the Northern Territory, Queensland, the Australian Capital Territory and Western Australia but in no other jurisdictions. Western Australia has used this data to evaluate liquor licensing restrictions in remote areas or Aboriginal communities, such as Derby, Halls Creek and Port Hedland and to monitor the consumption of different types of beverages (such as low strength, full strength beer, wine and spirits) over time and within particular populations.[33]

There are significant gaps in Australia's collection of alcohol data and this limits our understanding of alcohol-related harms and the effectiveness of strategies to reduce them. The NADK recommends that a national data repository be developed that collects alcohol-related data including consumption; harms; sales, treatment and vulnerable populations become a priority in a new National Alcohol Strategy (when this is developed).[31]

Recommendation 5: *That the Commonwealth Government develops a national data repository for alcohol-related harms.*

Recommendation 6: *That the South Australian, Victorian, Tasmanian and New South Wales Governments recommence the collection of alcohol sales data to better inform alcohol policy.*

Recommendation 7: *That the National Perinatal Minimum Dataset includes standardised questions about alcohol consumption during pregnancy.*

(d) scope for improving awareness of social determinants of health:

(i)in the community,
(ii) within government programs, and
(iii) amongst health and community service providers.

It is important that the general community, health and community service providers have a better understanding of how health is affected by the social determinants of health. However, it is most important that Governments increase their understanding of how knowledge of the social determinants of health can be used to achieve greater health outcomes for all Australians.

In 2010 the South Australian Government released its *Health in All Policies* strategy. This provides a useful example for how the Commonwealth Government can adopt a social determinants approach. This policy statement recognises that health and wellbeing are influenced by measures often outside of the health sector and aims to integrate health, wellbeing and equity in the development of all Government policies and services.

The South Australian Government has also developed mechanisms for cross-sector problem solving.[34] A whole of government commitment is achieved by engaging the head of government, cabinet and administrative leadership, and embedding responsibilities into government strategies through performance indicators, benchmarks and targets. South Australia has also created a Health in All Policies Unit within its Department of Health.

Knowing the social determinants of health is not enough to achieve changes to the health outcomes of Australians. This knowledge needs to be applied and Governments require incentives and mechanisms to work together to determine the potential impact on health of all public policy decisions.

Recommendation 8: *That the Commonwealth Government adopts a 'health in all policies' approach to public policy development which includes the establishment of health benchmarks and monitoring structures to ensure cross government action is being implemented and targets achieved.*

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