Flinders University | Southgate Institute for Health, Society and Equity

Australian National University

RegNet School of Regulation & Global Governance

PROMOTING HEALTH EQUITY: FROM KNOWING TO ACTION RESEARCH AND POLICY SYMPOSIUM

MONDAY 16 SEPTEMBER

PRESENTED BY

NHMRC Centre for Research Excellence in the Social Determinants of Health Equity.

#CREHealthEquity

PARTNERS

The University of Sydney | uOttawa | the Lowitja Institute

WELCOME
Introduction and Overview

Session Chair:

Professor Jonathan Craig
Vice President and Executive Dean
Flinders University

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Welcome to Country

Uncle Lewis Yerloburka O'Brien, AO

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#CREHealthEquity

Opening Address

The Honourable Dr Richard Harvey MP

Member for Newland

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NHMRC Centre for Research Excellence
in the Social Determinants of Health Equity

Overview of CRE Program and Policy Engagement

Professor Fran Baum AO,
Southgate Institute for Health, Society and Equity and CRE co-Director
@baumfran

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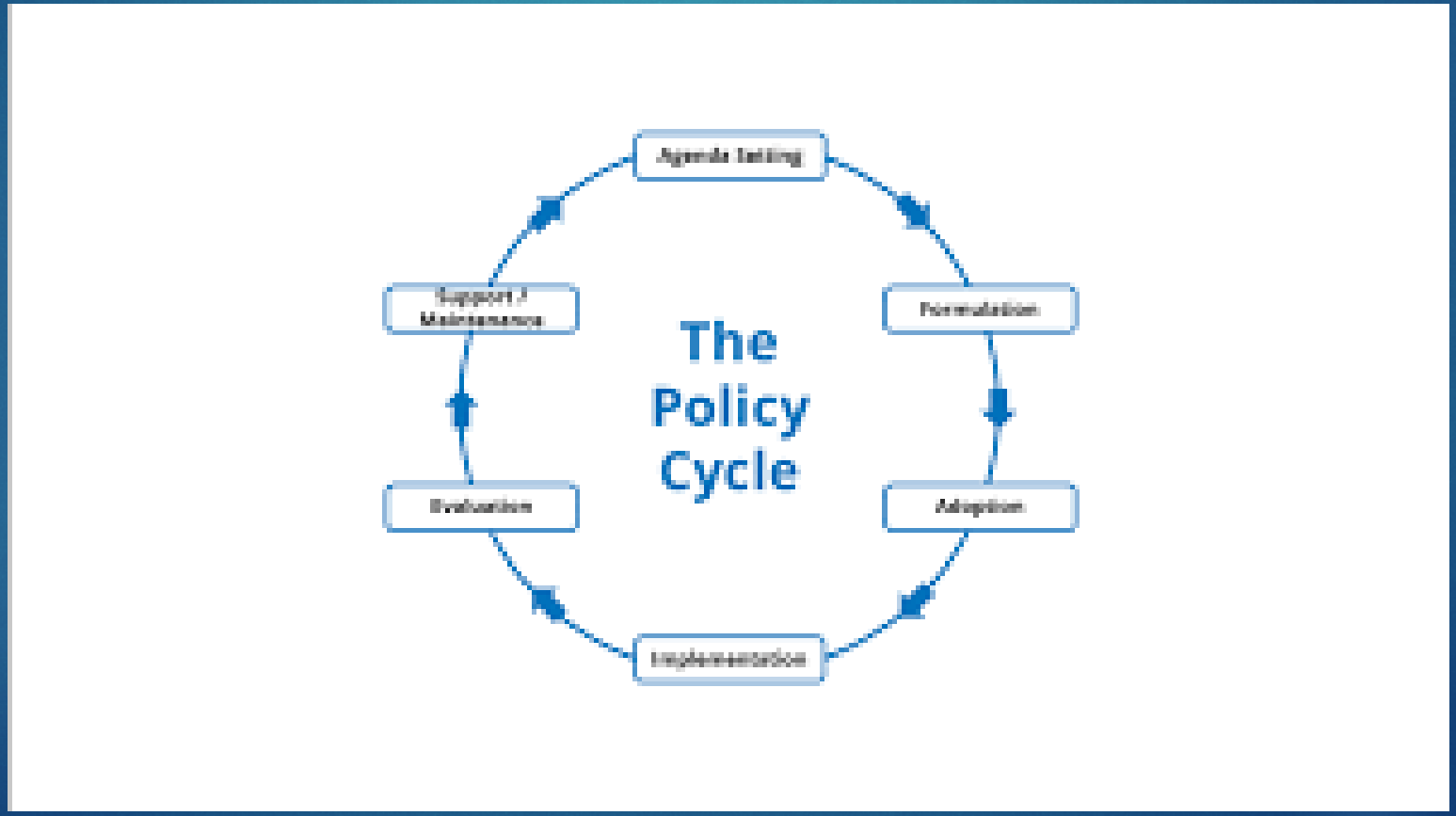
CRE Health Equity 2015-20

- NHMRC funding $2.5million
- Consider how policies promoting health equity can come on to policy agenda, be formulated, implemented and evaluated



CRE Health Equity - Launch, March 2015

Persistent health inequities

- Aboriginal and Torres Strait islander people die on average around 11 years earlier than other Australians (AIHW, 2015)
- Low income people lose about 6 years of life compared to better off Australians (Leigh, 2013)
- Gradient from high to low – affects all of us not just a question of “the disadvantaged”

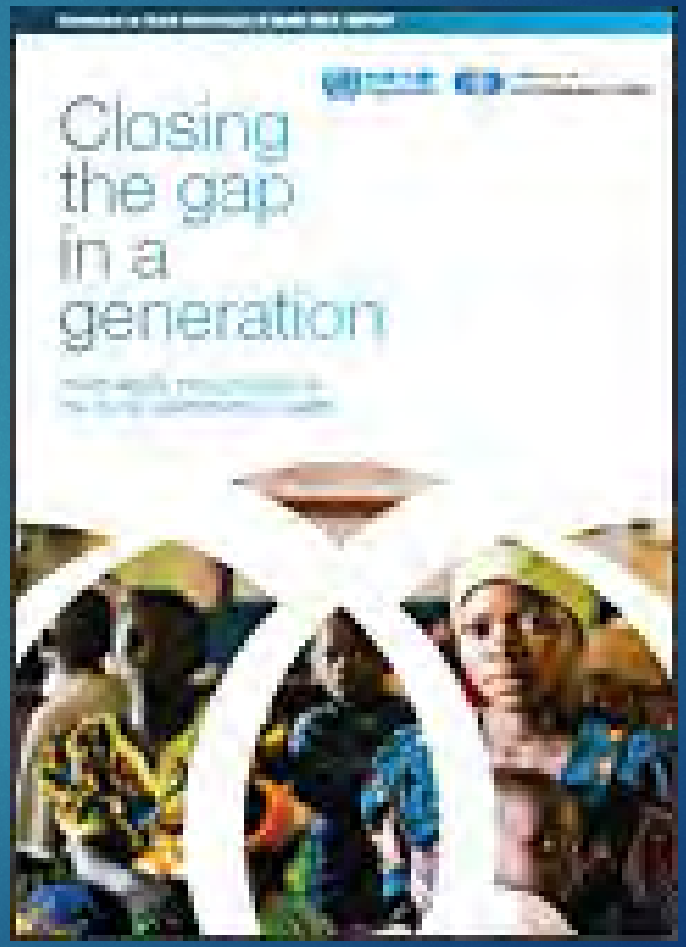
Table 2.1: Changes in the Health Inequality Ratio from 1997-2000 to 2011-2015 for Deaths from all Avoidable Causes

(Data source: Social Health Atlas, PHIDU, 2018).

State	Health inequalities ratio 1997-2001	Health inequalities ratio 2011-2015	Increase in inequality ratio
New South Wales	1.59	2.11	0.52
Victoria	1.32	1.85	0.53
Queensland	1.58	1.89	0.31
South Australia	**1.52**	**2.18**	**0.66**
Western Australia	1.64	2.26	0.62
Tasmania	1.4	2.03	0.63
Northern Territory	3.5	4.23	0.73
Australian Capital Territory	1.39	1.87	0.48
Australia	1.55	2.06	0.51

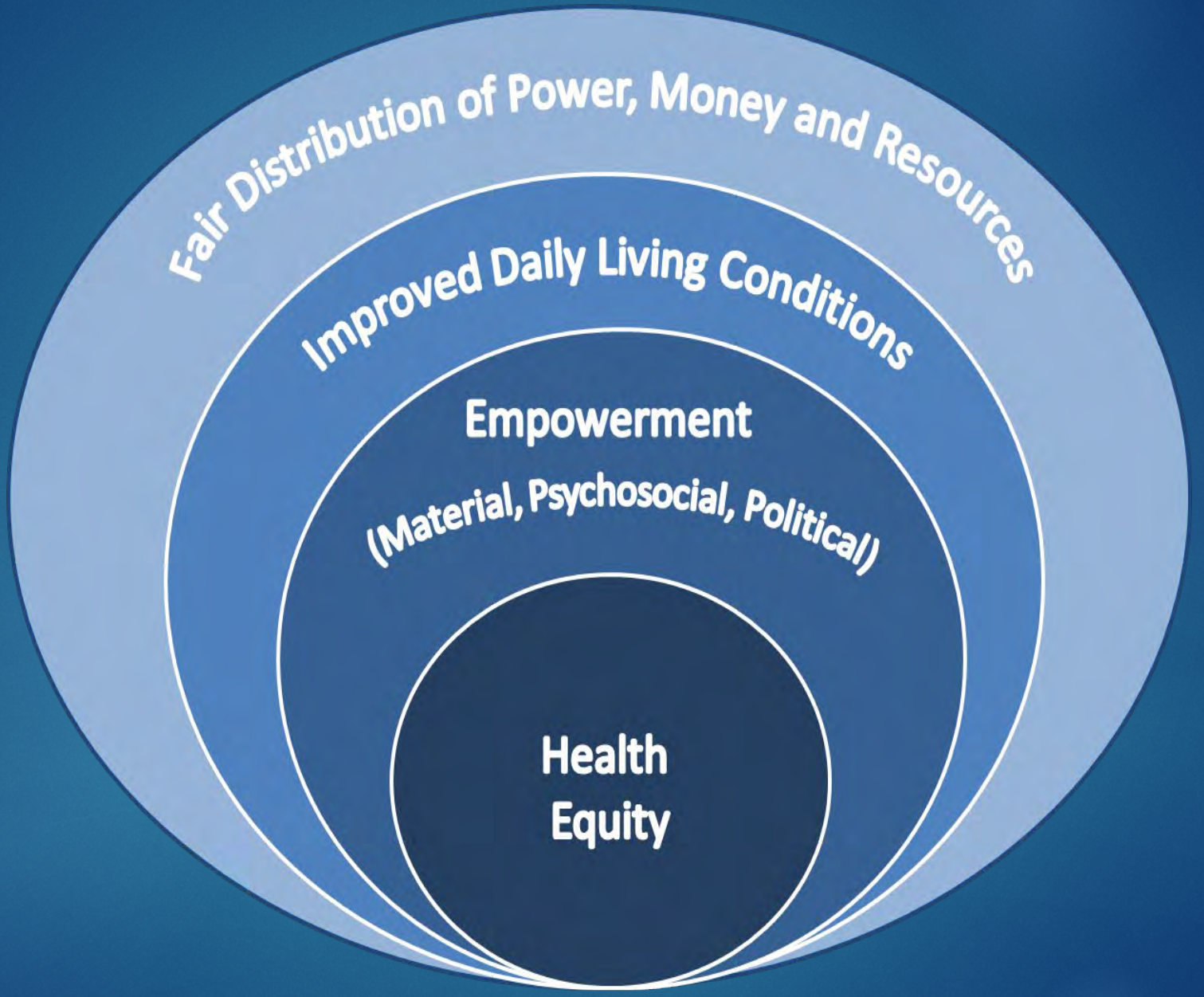
Commission on the Social Determinants of Health

- "*Health inequity really is a matter of life and death*" Margaret Chan DG WHO
- CRE Health Equity started from this report
- Australian Senate Committee recommended implementation of CSDH policy recommendations and more SDH research in Australia



Basic logic: what good does it do to treat people's illnesses/addictions/send them to gaol/.....

then give them no choice or no control over the conditions that made them sick/addicted/commit crime in the first place?



Amended WHO Commission on Social Determinants of Health 2008

Research Team

- Co-Directors: Fran Baum (FU) & Sharon Friel (ANU)
- Other Chief Investigators: Ron Labonte (U Ottawa), Adrian Kaye (ANU) Lyndall Strazdins (ANU), Dennis McDermott (FU) Anna Ziersch, Patrick Harris (USyd), Tamara McKean (FU) John Spoehr(FU)
- Research staff: Phil Baker (ANU) , Kathryn Browne-Yung (FU), Gemma Carey (ANU), Matt Fisher (FU), Bel Townsend, Ashley Schram, Toby Freeman

Associate Investigators

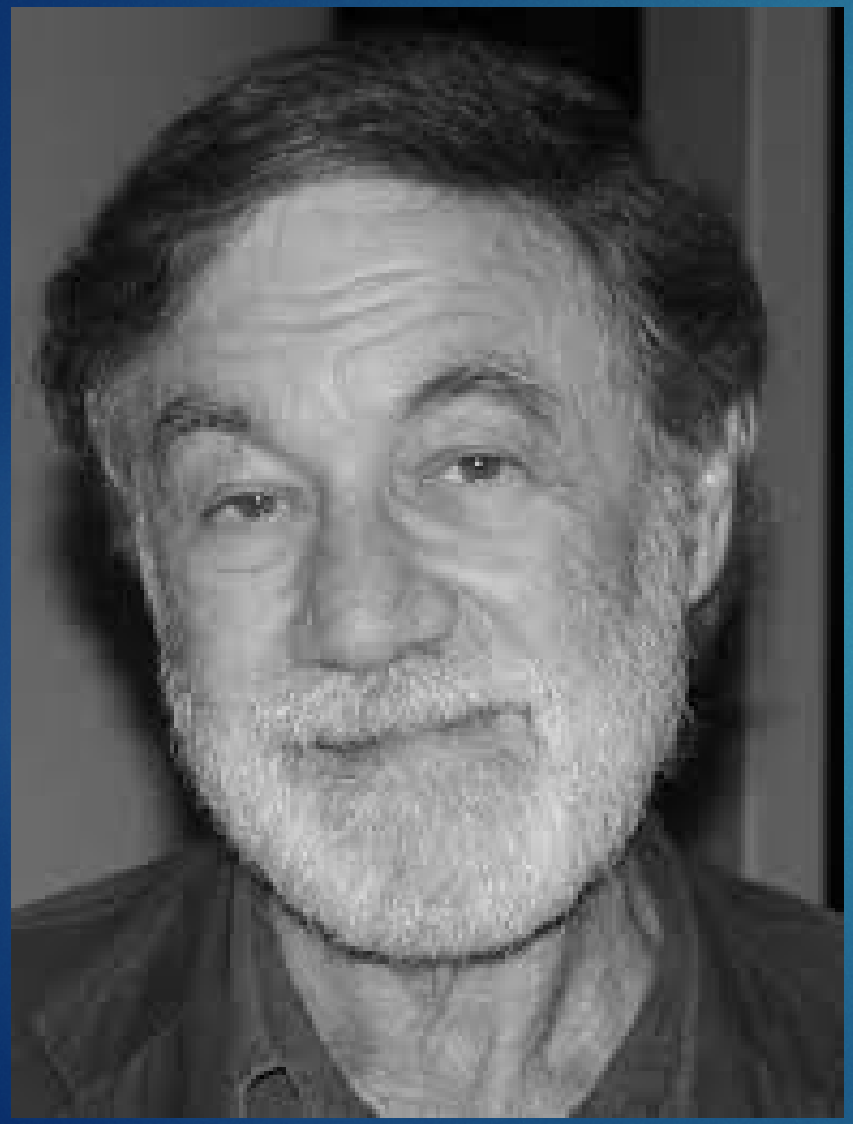
International

- Professor David Sanders, University of the Western Cape, South Africa
- Professor Sir Michael Marmot, Institute Health Equity, UCL
- Professor Margaret Whitehead, University of Liverpool, England
- Professor David Stuckler, Oxford University, UK
- Associate Professor Louise Signal, University of Otago, New Zealand
- Professor Malcolm King, Simon Fraser University, British Columbia, Canada

National

- Dr Michael Tynan, Lowitja Institute
- Professor Michael Quinlan, University New South Wales
- A/Prof Liz Harris, University New South Wales
- Mr Justin Mohammed, Chair, National Aboriginal Community Controlled Health Organisation

Professor David Sanders 1945-2019



Dr. Tedros Adhanom Ghebreyesus DG WHO

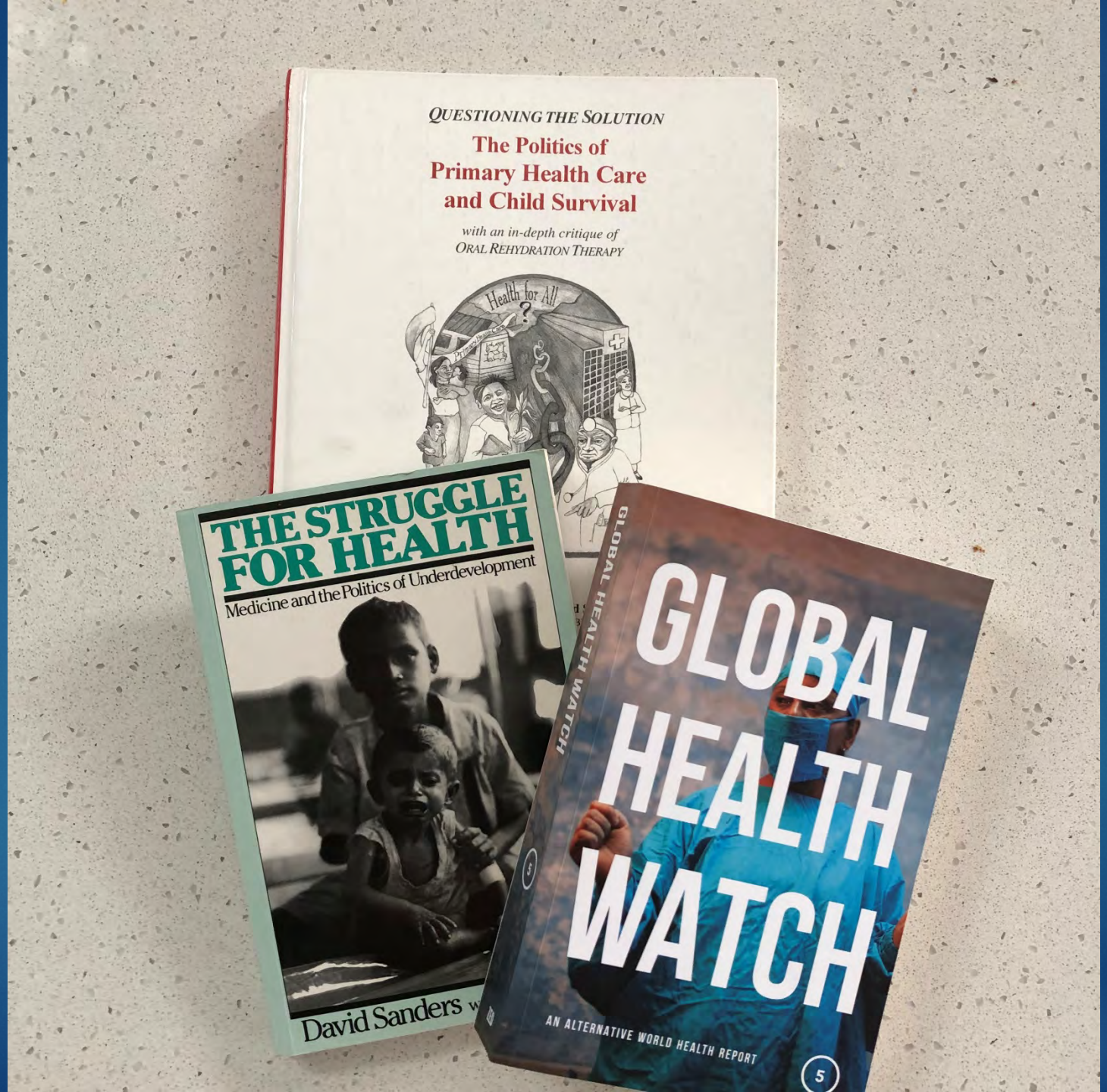
“Saddened by the news about David Sanders’ passing. An enormous loss for the public health community. We will honour his legacy in our continuing quest for #HealthForAll”.

Zweli Mkhize - South African Health Minister

David Sanders “ was a fierce critic of the impact of neoliberalism on the health of people. He was not only an accomplished researcher, academic and mentor to many but also a leader of social movements, including the People’s Health Movement”

Professor Mary T Bassett Harvard TH Chan School of Public Health

"His activism should not obscure from his commitment to research. David was determined that we make a statement- using our research skills- on this extremely damaging policy (structural adjustment). He encouraged me to apply for academic promotion. I would probably have remained a junior lecturer. This selfless generosity was not special to me- it was replicated over and over again among the many he knew. I was honored to give the David Sanders lecture at the UWC SOPH, the institution he worked so hard to build..... We don't get people like David Sanders very often: A fearless public intellectual and a good friend. The best way to honor him is to carry on his commitment to the struggle for health".


QUESTIONING THE SOLUTION
The Politics of Primary Health Care and Child Survival
with an in-depth critique of ORAL REHYDRATION THERAPY
Health for All?
THE STRUGGLE FOR HEALTH
Medicine and the Politics of Underdevelopment
David Sanders
GLOBAL HEALTH WATCH
GLOBAL HEALTH WATCH
AN ALTERNATIVE WORLD HEALTH REPORT
5

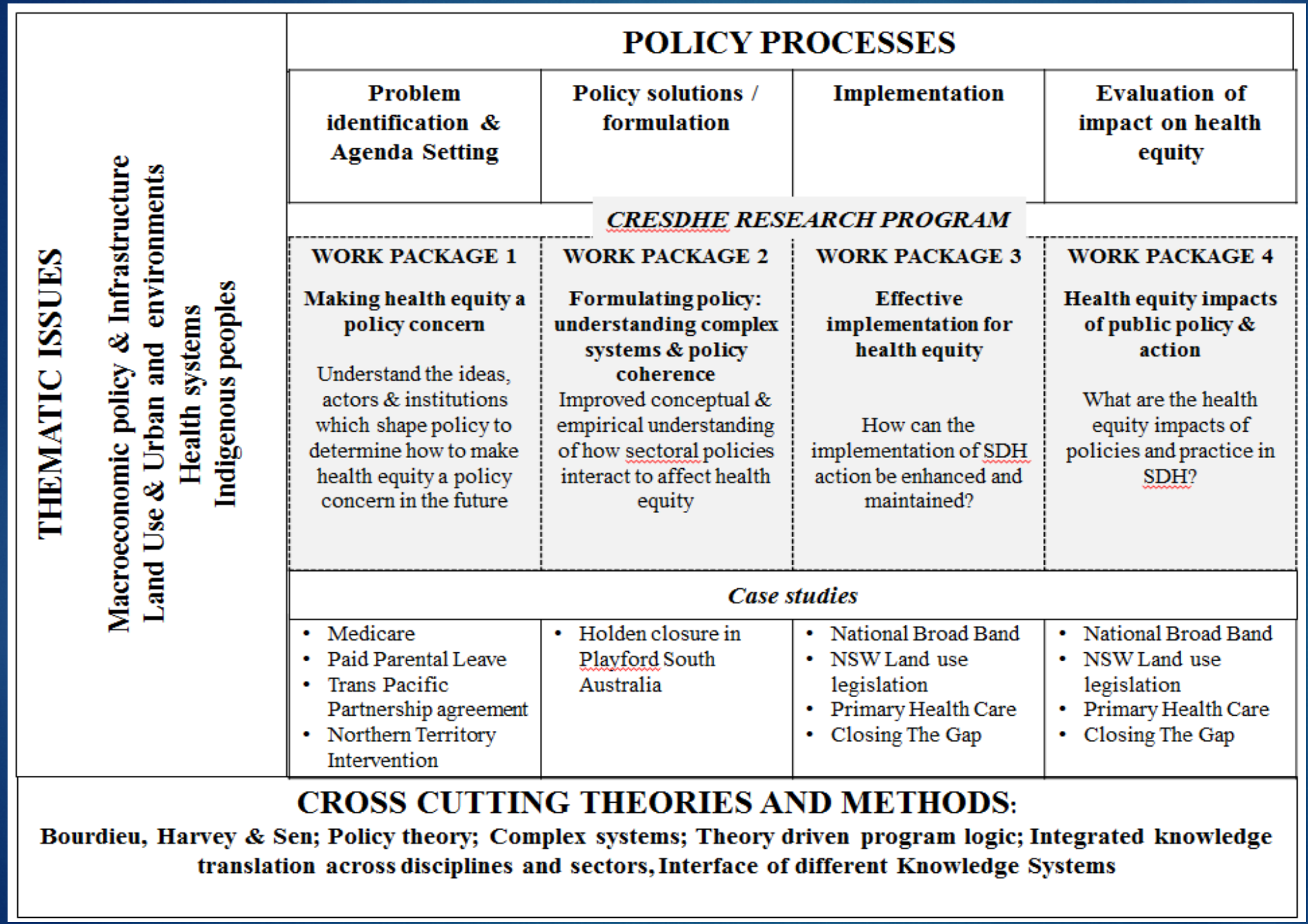
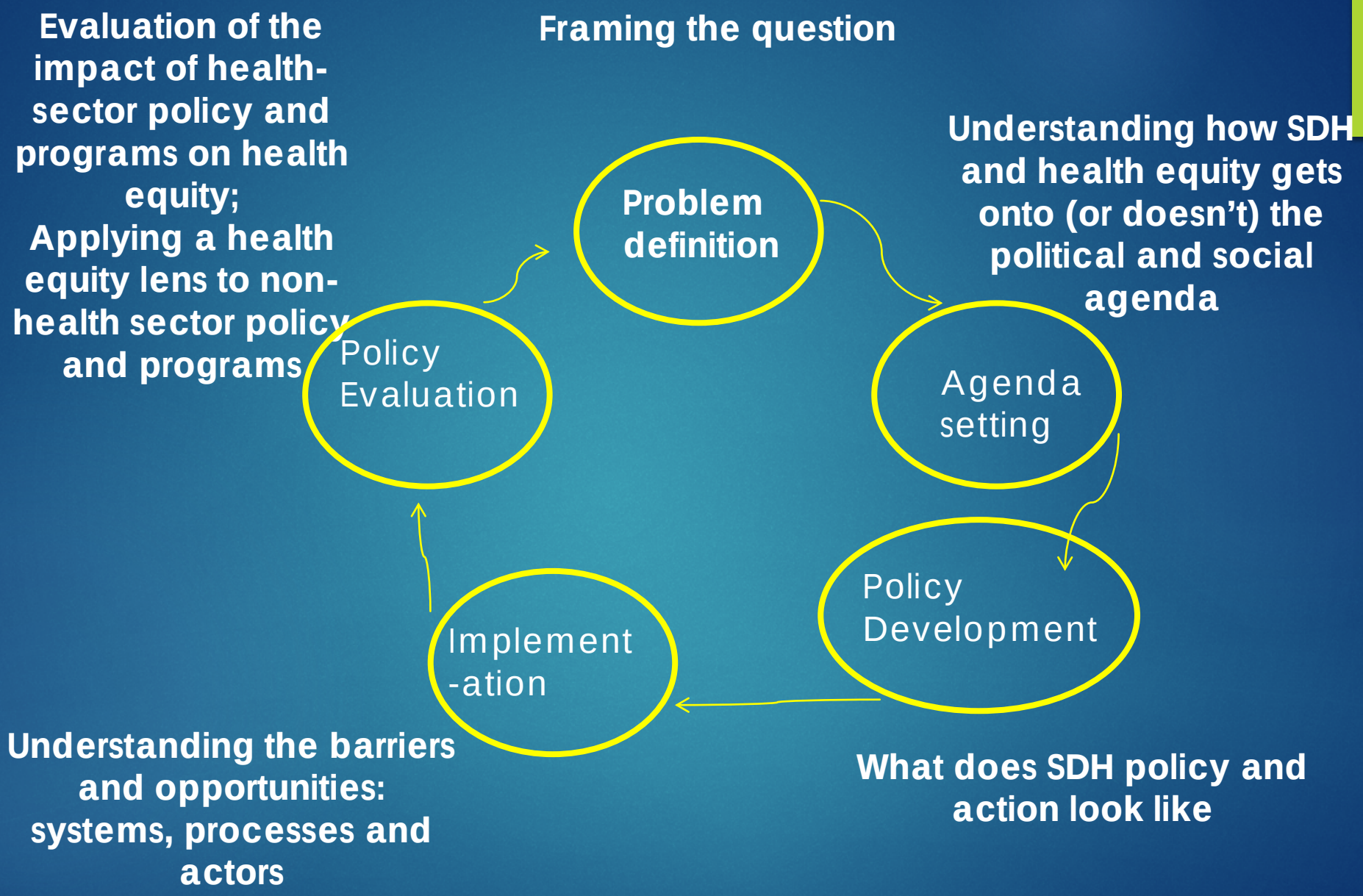


Table from original grant



NHMRC Centre of Research Excellence on Social Determinants of Health Equity (CRESDHE): Policy research on the social determinants of health equity, 2015-2020.

Work Package 1: Setting the agenda

Policy making occurs in a ‘cauldron’ where ‘problems’, ‘politics’ and ‘policy processes’ are swirling around and windows of opportunity present themselves

Case Studies:

Trans-Pacific Partnership Agreement and Health

Northern Territory Intervention

Paid Parental Leave

Kingdon 2003. Agendas, Alternatives, and public policy, 2nd ed. Longman, New York.

Real time study of policy complexity

Case Study of Holden Closure, Elizabeth, SA De-industrialisation

How do policies interact to influence health equity

Work Package 3: Implementation

Aim: To determine what mix of actors, values, institutional practices and systems makes for successful policy implementation to contribute to health equity

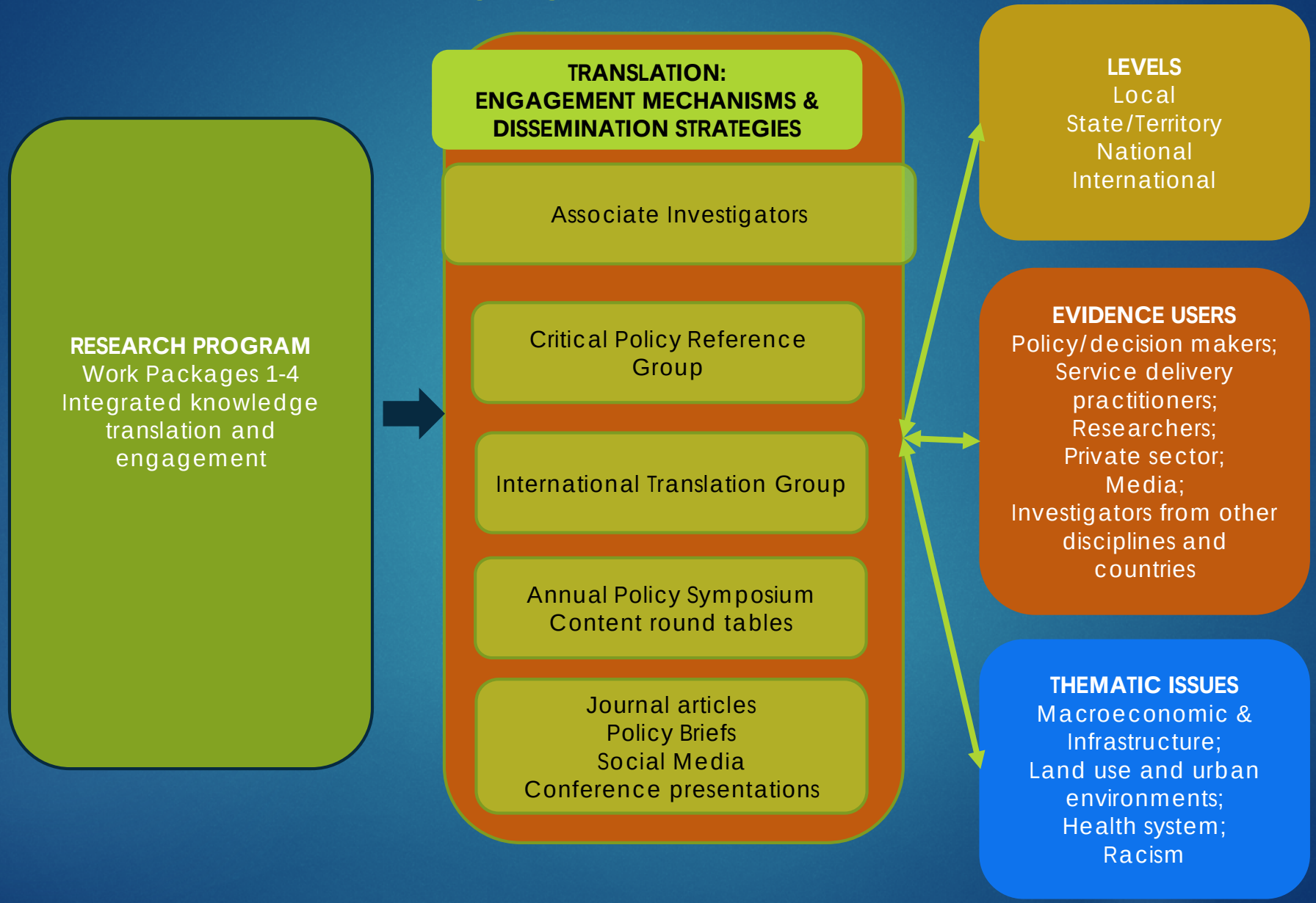
Case studies:

- National Broadband network
- NSW Land use legislation
- Primary Health Care
- Closing the Gap

Work Package 4: Impact

- Health equity impact from case studies
- Develop new methods for assessing policy impact drawing on our existing research on Health Impact Assessment, Program logic evaluation and epidemiological attribution
- Model health loses and gains from policy choices

Translation-engagement mechanisms



CRE Critical Policy Reference Group (Sept 2019)

Associate Professor Peter Sainsbury, former NSW Health (Chair)

Dr Tessa Boyd-Caine, Health Justice Australia

Ms Liz Callaghan, Australian Department of Health

Dr Siobhan Harpur, Department of Health, Tasmania

Professor David Legge, La Trobe University

Dr Felicity Ann Lewis, President Australian Local Government Association

Professor Rob Moodie, University of Melbourne

Professor Michael Moore AM, former CEO Public Health Association of Australia (PHAA)

Ms Jacqueline Phillips, Australian Council of Social Service

Dr Pat Ranald, Australian Fair Trade and Investment Network

Dr Melissa Sweet, Independent Public Health Journalist

Ms Norma Shankie-Williams, Willoughby City Council

Ms Carmel Williams, Partnerships Branch, Public Health Division, SA Health

Ms Janine Mohamed, Lowitja Institute

Engagement, translation and making a difference

CRE Symposiums

- 24 April 2015 Launch of NHMRC CRE on Social Determinants of Health Equity

  "Action to improve health equity: Ways to create a sustainable revenue base"
- 12 May 2016 "A fair go for all: Addressing social and health inequities in Australia and internationally“
- 21 Sep 2017 "De-industrialisation: Employment, health and equity impacts for people and communities"
- 29 Nov 2018 "The 10 Year Rollercoaster of Global Health Equity: Power, Progress & Pitfalls"
- 16 Sep 2019 "Promoting Health Equity: From Knowing to Action“

- Topic specific: Primary Health Care (Parliament House and Public) Paid Parental Leave, Trade and heath, Aboriginal and Torres Strait Islander organisation engagement
- Multiple meetings with politicians and other policy makers and civil society actors
- Policy briefings

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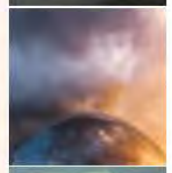
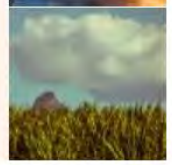
RegNet co-hosts roundtable on paid parental leave
...
Conversations 2019: Narration and renarration as regulation
...
Information, Technology and Control in a Changing World - new book co-edited by Kathryn Henne
Labour Lines and Colonial Power - new book co-edited by Jon Altman



OUR PEOPLE

EVENTS

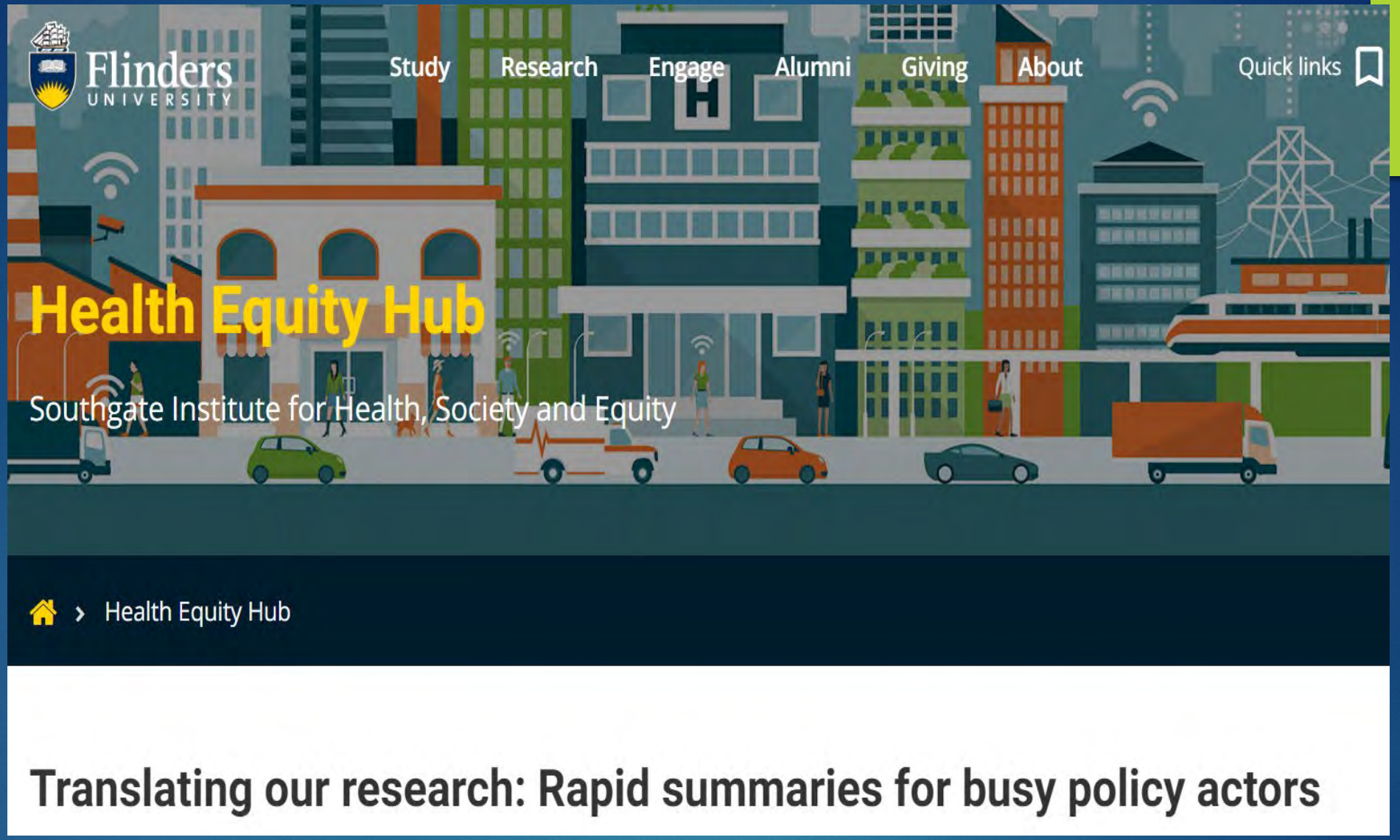
17 Sep — Narration and re-narration through multiple genres and creative media

23 Sep — Tell Your Story workshop with editor Nadine Davidoff

24 — Changing the story book: Re-

LATEST NEWS

http://regnet.anu.edu.au/



https://www.flinders.edu.au/healthequity-southgate

Summary of achievements

- Knowledge advance in how public policy includes or excludes health equity and detailed understanding of how the processes happen and in measuring the outcomes of policy
- Theoretical advance in use of public policy theory and application of theories that explain inequities (Harvey, Bourdieu)
- Information and knowledge on a range of topics that are used actively by policy actors
- Raising awareness through engagement events, social media and policy briefing of health equity and social determinants of health
- Training for a cohort of mid-career early career and PhD scholars in public health social science empirical research and research engagement and translation
- Seeding new research ideas and research partnerships

SESSION 1
Infrastructure for Health and Equity

Session Chair:

Sandy Pitcher
Chair, Environment Institute
University of Adelaide

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Infrastructure for Health and Equity

The National Broadband Network and Urban Planning in Greater Sydney

- Matt Fisher
- Patrick Harris
- Toby Freeman
- Ashley Schram
- Sharon Friel
- Fran Baum

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Infrastructure, urban environments and health

- Infrastructure and the built environment are key determinants of health
- Infrastructure: sanitation, water, electricity, transport and telecommunications
- Urban planning: from healthy built environment to economic growth and ‘competitive’ cities
- Infrastructure and urban planning policy not coordinated effectively
- Healthy urban environments in Australia inequitably distributed
- Health and environmental impacts of infrastructure and built environment will be long-lasting

Infrastructure, urban environments and health

- Research on the National Broadband Network and recent Urban Planning policy in Greater Sydney
- Built environment as a determinant of health (e.g. air pollution, greenspace, social connection/isolation, food and exercise)
- Since 2008 majority of world's population live in urban environments
- Telecommunications as a *mediator* of health determinants
- Inequalities in access likely to have an effect on health inequities

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in the Social Determinants of Health Equity

NBN

Dr Toby Freeman and **Dr Matt Fisher**
Flinders University
@drtobyfreeman
#CREHealthEquity

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The National Broadband Network

How equity got lost in implementation

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Context

- Previously public telecommunications provider, since privatised
- Universal service obligation
- Lack of investment in next gen infrastructure → government intervention

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2007
Labor government elected

2008
Labor government unsuccessfully puts network out for tender for FTTN, and then switches policy to FTTP.

2009
Labor government establishes NBN Co as a hybrid public-private entity to rollout FTTP network

2013
Labor replaced by Coalition government. Rollout changed to multi-technology mix.

2017
Rollout halfway mark reached

2020
Rollout due to be completed

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NBN: The original policy formulation

Government's NBN Vision and Objectives

The Government's central NBN objectives are to deliver significant improvement in broadband service quality to all Australians, address the lack of high speed broadband in Australia, particularly outside of metropolitan areas, and reshape the telecommunications sector. The Government recognises that access to affordable high speed broadband is essential to the way Australians communicate and do business. It will drive productivity, improve education and health service delivery and better connect our cities, regional, rural and remote communities.

Wong & Conroy, Statement of Expectations 2011

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So Just How Borked Is The NBN?

Tooran Alizadeh | Edward Helderop | Tony Grubesic |

Jul 3, 2019, 4:00pm· Filed to: Australian Stories

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NBN policy 2008-2013

- Interested in:
  - equity in the resulting infrastructure
  - the political/implementation processes that supported or constrained equity

What we can learn about infrastructure policy generally

NBN policy 2008-2013: Not perfect at the start

- Public/private policy structure
  - Public funding
  - NBN Co - government-owned company; monopoly wholesaler
  - Competitive retail market to sell services
- High risk of political criticism of public spending → loan, recouped when sold
- ⇨ 3 competing imperatives:

  universalist, financial, political
- From inception, 7-10% premises (rural/remote) on satellite, fixed wireless

"NBN as a government enterprise was really about keeping it off the balance sheet"

(NGO representative)

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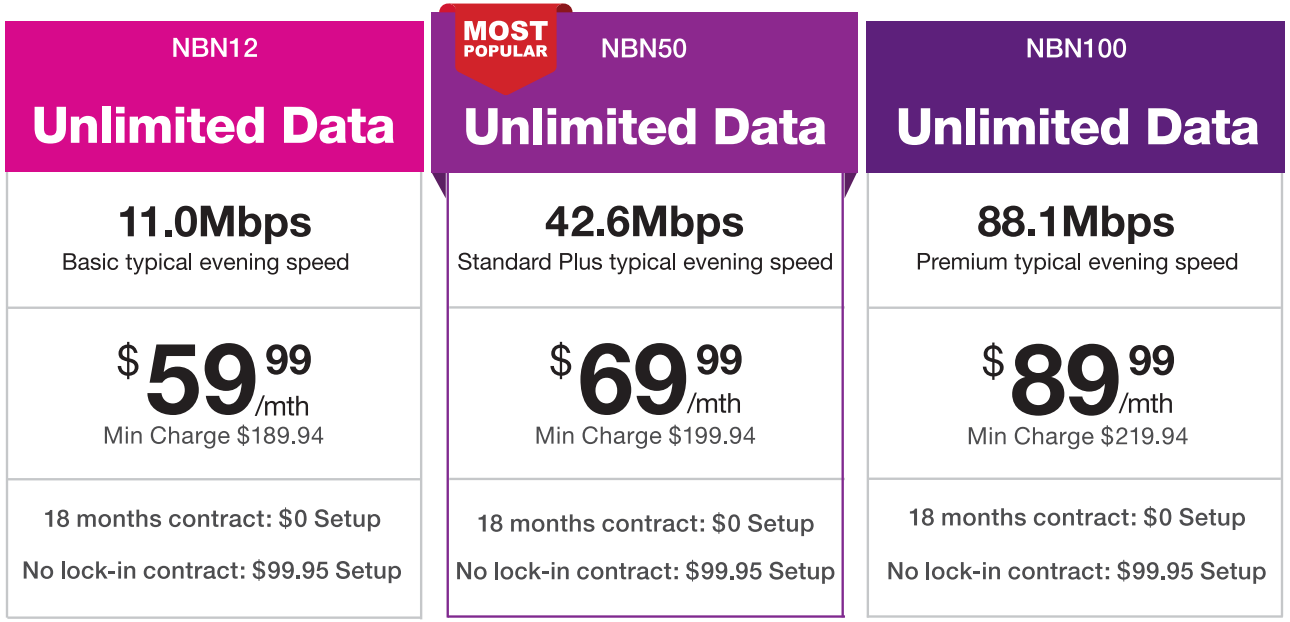
NBN policy 2008-2013 – competing imperatives

- Affordability
  - ☑ Regulatory controls to protect affordability (universal wholesale pricing)
  - ☑ Wanted to ensure affordability did not decrease
  - ☒ Imperatives for commercial returns on investment → higher prices, speed tiers



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Broadband costs rank among worst in world

Matt Coughlan National

SHARE TWEET

Australia is one of the least affordable countries for entry-level broadband.

Australia has the least affordable entry-level access to broadband among developed economies, ranking 67 out of a wider list of 83 countries.

Change in NBN policy – 2013-2019

- Political opportunism from Liberals in 2013
  - Stoke public fears about government spending
  - Criticise 'delays' in implementation
  - Neoliberal economic framing: consumers, not common good
- 'Faster and cheaper' implementation
- The 'multi-technology mix'
  - Fibre to the home
  - Fibre to the node
  - (Telstra/Optus) HFC cable
  - Wireless
  - Satellite

"I think the real reason [for the multi-technology mix policy] was that the Coalition saw political advantage in being seen to be doing something different from what Labor was doing."

(Key informant)

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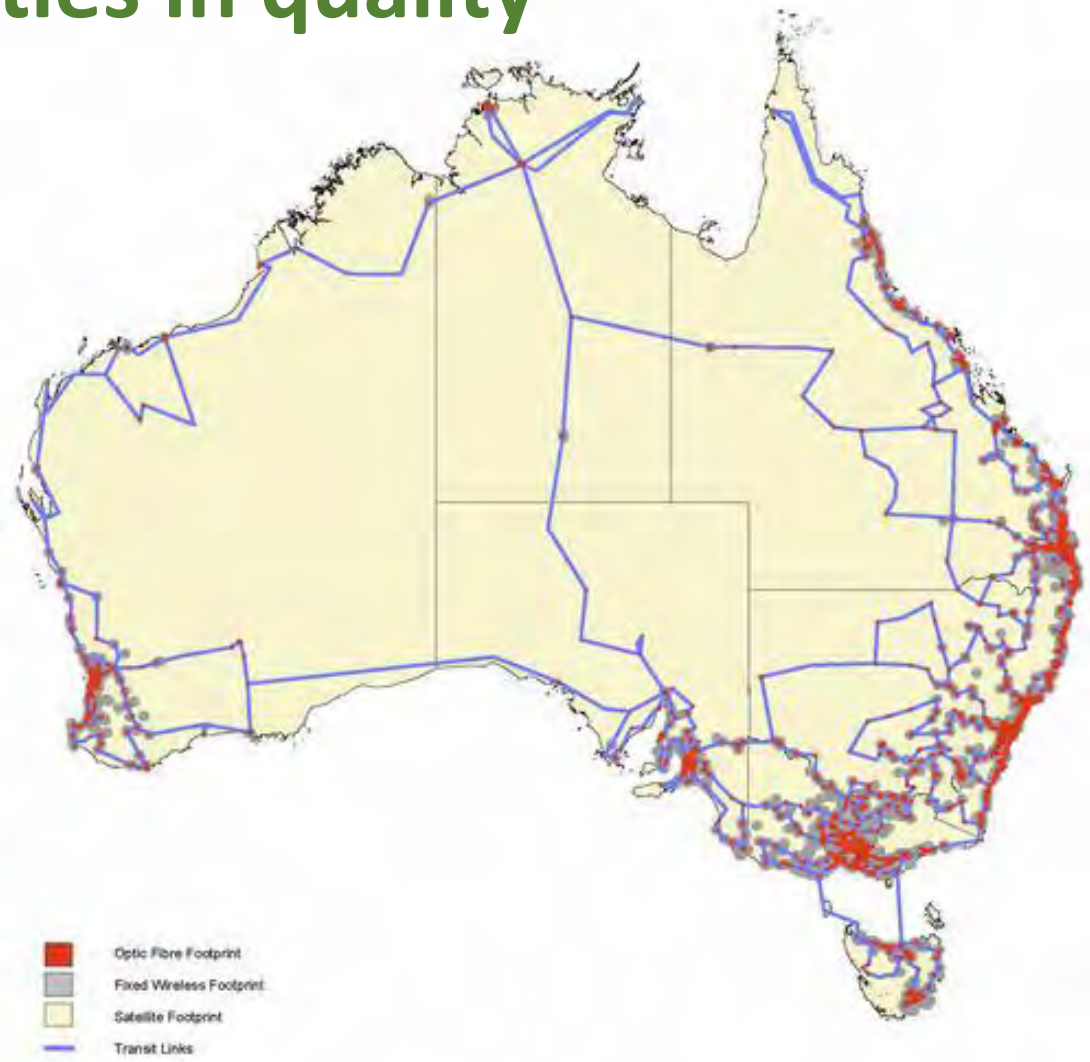
NBN policy 2008-2019 – inequities in quality

- Inequity in quality
  - Fibre to the home / curb +++
  - Fibre to the Node / HCF ++
  - Wireless services ++
  - Satellite +



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Outcomes for equity & public policy

☑ Universal access to new (and re-purposed) infrastructure for HSB and fixed-line phone

☒ Increased differences in the *quality* of infrastructure and services

☒ Inequitable distribution

- Higher income areas have got better quality infrastructure and services*
- Rural and remote areas get the worst quality services
- Inequities will matter more as demand for data speeds increases

☒ Major risks for stranded infrastructure, more costs, NBN privatisation

* Schram et al. (2018). Digital Infrastructure as a Determinant of Health Equity: An Australian Case Study of the NBN. *Australian Journal of Public Administration, 77829-842.*

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Urban Planning in Greater Sydney: Lessons for other jurisdictions

Dr Patrick Harris
University of Sydney
@PHarrismusings
#CREHealthEquity

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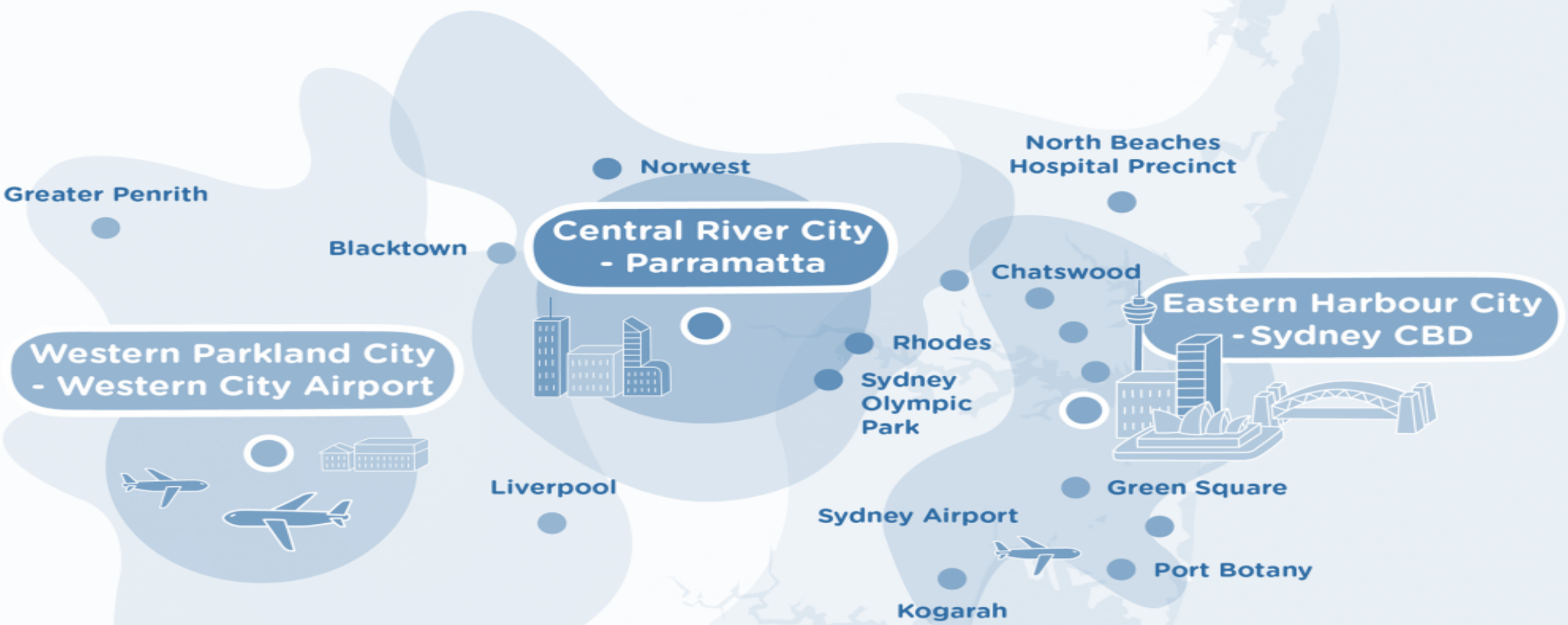

Urban Planning meets infrastructure in Greater Sydney

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Urban design, transport, and health 1

City planning and population health: a global challenge

Billie Giles-Corti, Anne Vernez-Moudon, Rodrigo Reis, Gavin Turrell, Andrew L Dannenberg, Hannah Badland, Sarah Foster, Melanie Lowe, James F Sallis, Mark Stevenson, Neville Owen

Significant global health challenges are being confronted in the 21st century, prompting calls to rethink approaches to disease prevention. A key part of the solution is city planning that reduces non-communicable diseases and road trauma while also managing rapid urbanisation. This Series of papers considers the health impacts of city planning through transport mode choices. In this, the first paper, we identify eight integrated regional and local interventions that, when combined, encourage walking, cycling, and public transport use, while reducing private motor vehicle use. These interventions are destination accessibility, equitable distribution of employment across cities, managing demand by reducing the availability and increasing the cost of parking, designing pedestrian-friendly and cycling-friendly movement networks, achieving optimum levels of residential density, reducing distance to public transport, and enhancing the desirability of active travel modes (eg, creating safe attractive neighbourhoods and safe, affordable, and convenient public transport). Together, these interventions will create healthier and more sustainable compact cities that reduce the environmental, social, and behavioural risk factors that affect lifestyle choices, levels of traffic, environmental pollution, noise, and crime. The health sector, including health ministers, must lead in advocating for integrated multisector city planning that prioritises health, sustainability, and liveability outcomes, particularly in rapidly changing low-income and middle-income countries. We recommend establishing a set of indicators to benchmark and monitor progress towards achievement of more compact cities that promote health and reduce health inequities.

Published Online
September 23, 2016
http://dx.doi.org/10.1016/S0140-6736(16)30066-6

This is the first in a Series of three papers about urban design, transport, and health

University of Melbourne, Melbourne, VIC, Australia (Prof B Giles-Corti PhD, H Badland PhD, M Lowe PhD, Prof M Stevenson PhD); University of Washington, Seattle, WA, USA (Prof A Vernez-Moudon Dr ès Sc, Prof A L Dannenberg MD); Pontifical Catholic University of Parana, Parana, Brazil (Prof R Reis PhD); Washington University at St Louis, St Louis

BUT How Does ‘Integrated’ Planning (for Health and Equity) happen?

“Let’s form a committee to create a task force to develop a team to determine the fastest way to deal with the problem.”

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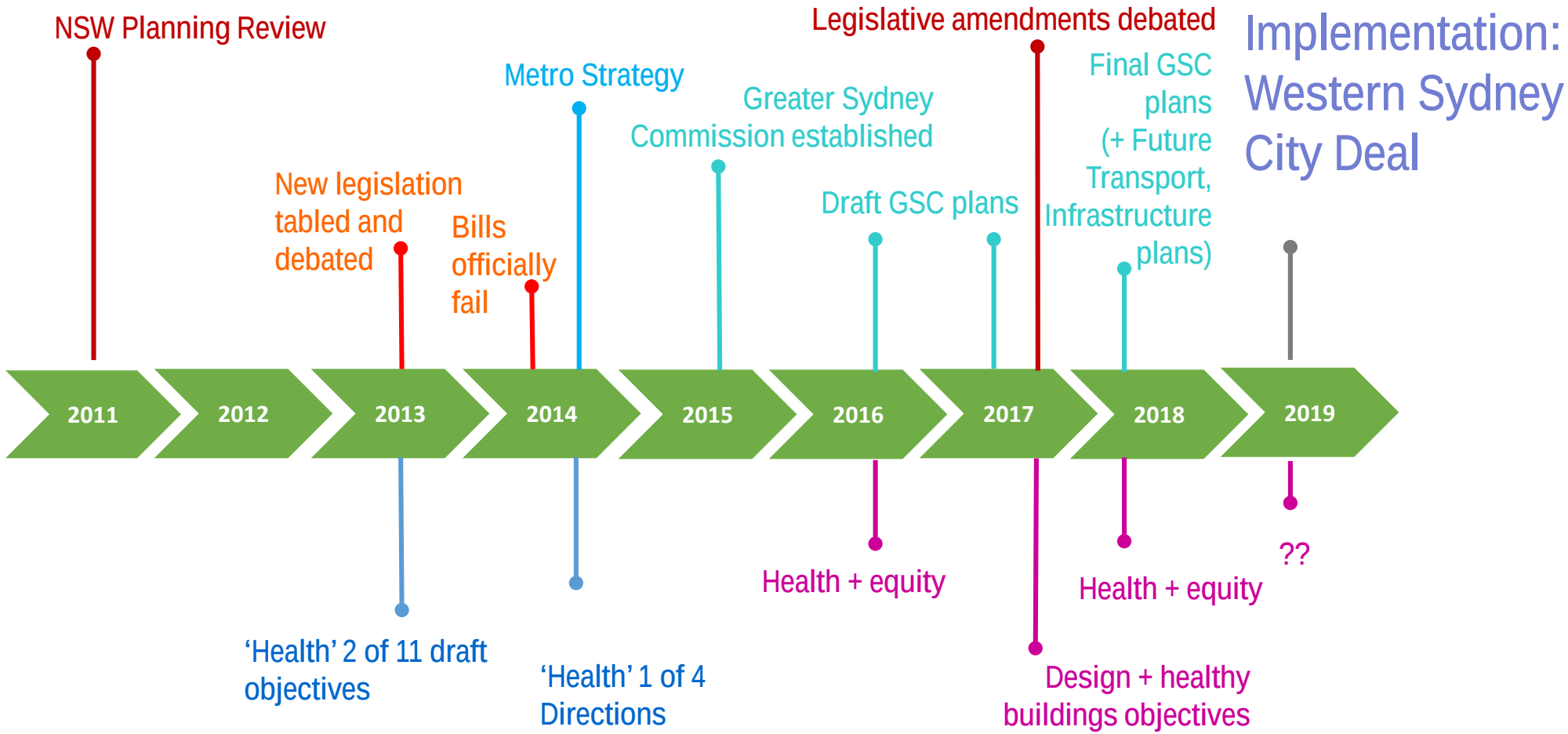
NSW Planning system activity and health's incremental inclusion



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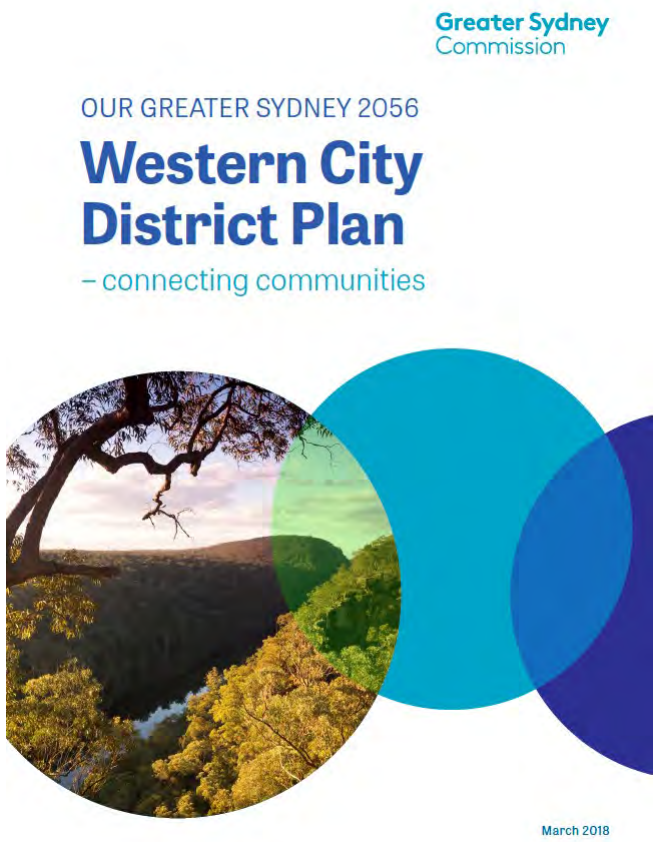
Western Sydney City Deal



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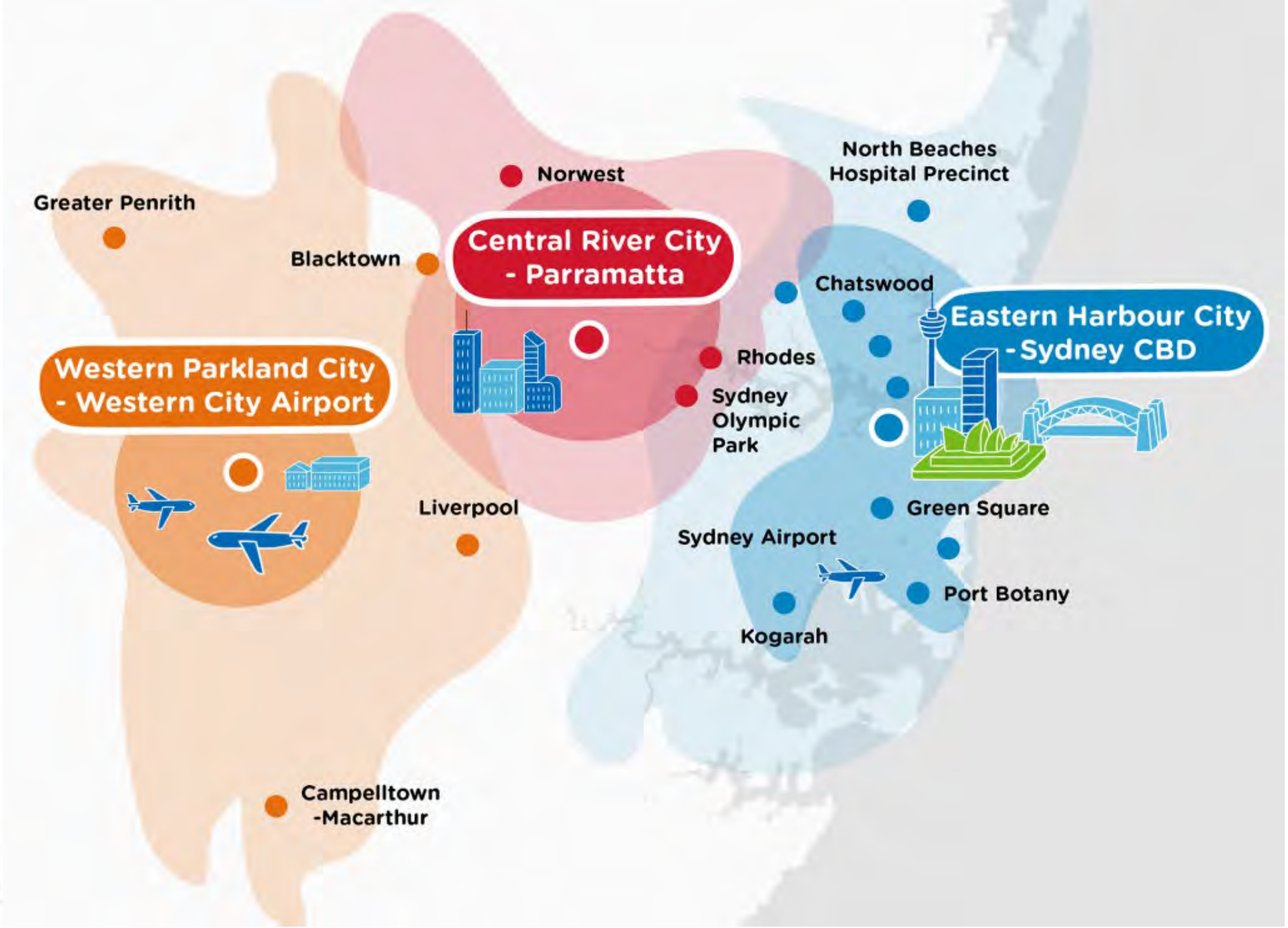

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COMMITMENTS FRAMEWORK
for the City Deal

Liveability and Environment	
Measuring performance	Liveability and Sustainability The liveability and sustainability performance metrics can help all levels of government, industry and the community to better target policies aimed at promoting safety, social cohesion and human health and improving the quality of the local environment. Performance indicator · Access to green space area
Amenity and liveability across the Western Parkland City	
L1 - Western Parkland City Liveability Program	
Improve community health	
L5 - Western Sydney Health Alliance	
Commitment	Local governments, in collaboration with health partners, will establish the Western Sydney Health Alliance to improve coordination and effectiveness of health services in the region, supporting healthier neighbourhoods.

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thrive
J9, J10
More job opportunities
J11a, J11b

L5

'What are the mechanisms and conditions surrounding the development of the Western Sydney City Deal as an example of strategic planning meeting infrastructure delivery to achieve health and equity?'

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Methods

1. Interviews
2. Critical discourse analysis of WSCD implementation plan
3. Theoretical redescriptions using (urban) theories of the policy process

How the Deal came about

Windows of opportunity *coming together:*

"the Commonwealth decision to proceed with the airport was an economic catalyst for Western Sydney…. And then at the same time, you've got [a Prime Minister who] likes the idea of city deals and who then decides we'll implement a city deal in Western Sydney. And at the same time you've got the New South Wales government through the GSC doing their work around district plans and region plans and so forth. And [the Deal] is a vehicle to implement the district plan for outer Western Sydney, with the airport as an economic catalyst."

But crucially, this same informant observed that

"$5.3billion is a significant investment, ***so how do you maximize the benefits of that more broadly in the wider precinct?"***

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Harvey (1989) on new entrepreneurialism	The discourse in the Deal
Competition for labour and capital means creating or exploiting opportunities to gain competitive advantage for the production of goods and services	Increased business investment to 'deliver transformative change to the region'.
New urban entrepreneurialism rests on public and private investment in infrastructure to strengthen the economic base of the metropolitan region as exporter of goods and services	The Deal 'builds on the Australian Government's $5.3 billion investment in Western Sydney Airport, which will be a catalyst for economic activity and job growth'.
The positive potential for urban entrepreneurialism to create positive change through 'agglomeration economies and efficient organisation'	This type of discourse dominates the whole Deal. For instance commitments for 'Investment and Industry Attraction', 'expanding agribusiness opportunities', and 'supporting indigenous businesses to thrive'
Hardly any large scale development occurs without local government offering a substantial package of inducements	The overall discourse in the plan leans toward government investment to open up the region for investment and employment .

Equity? Yes… … And No

- All informants were concerned with inequitable health outcomes experienced by people in the region relative to the rest of the city.
  - The Deal itself was seen by most as an opportunity to 'rebalance' infrastructure investment to the benefit of the West
  - equity was described by most informants in language emphasising the economic growth of Western Sydney as a competitive 'City Region'
- 'city-regional' equity misses sufficient consideration of how the Deal would address social and economic inequalities *within* the region.
- The discourse in the Deal emphasises branding the region for investment and avoids tackling disadvantage or vulnerability.
- No articulation of the need for services or social (as opposed to economic) supports for those who are not 'business leaders and entrepreneurs'.

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Place based planning and infrastructure?

“there’s a few structural things that needed to happen because to be honest, it was almost impossible and still remains almost impossible to do…

… our federated system, conspires [against] ***place based tri government joined up approaches*** *to delivering a complex system of outcomes* ***rather than an airport or housing or open space****.*

… This is a burning platform, and unless you’ve ***got the right ingredients of the orchestra****, unless you’ve got a conductor and a concept master and somebody leading the fiddle section and somebody leading the brass section, it’s just won’t happen.”*

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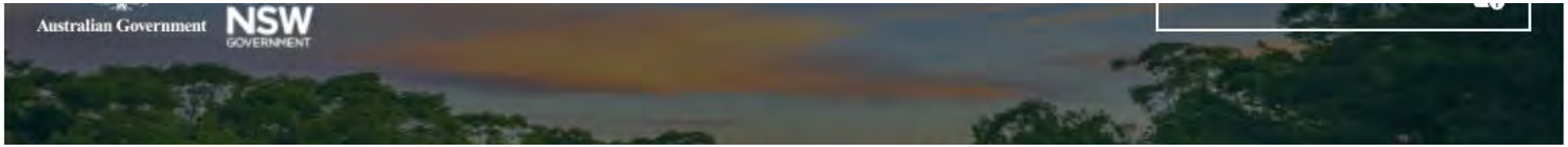
City



Community partnership

I4 - Work with Indigenous organisations to maximise opportunities

Commitment	The three levels of government commit to work with Indigenous organisations in the Western Parkland City, to realise economic, social and cultural outcomes for Aboriginal people in Western Sydney.
Key deliverables and milestones	Q2 2019 – Stakeholder engagement commences
Responsibility	Led by the NSW Government in cooperation with the Australian and local governments.
Financial Commitments	Existing agency resources.

The NSW Government will create a new planning partnership with the growth councils – Liverpool, Penrith, Campbelltown, Camden, Wollondilly – in conjunction with Blacktown to achieve more efficient and higher quality outcomes.

reater Penrith
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In summary

- In the face of significant institutional challenges WSCD sets up a tri-level governance structure aiming for a place based approach to infrastructure leveraging off airport
- The Plan's discourse emphasises power of the market and capital for the benefit of the region = investment and 'branding' focus but ignores equity.
- Speculative infrastructure based capital accumulation in a volatile global market, especially around air travel in an era of climate change, is risky
- Locally, a deeper engagement with existing and future vulnerability and disadvantage is essential to create a better region for all.
- A democratic and community-engaged approach to governance for local place-making is necessary but looks unlikely

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Government's role in infrastructure & planning for health equity

- Universal access to infrastructures delivering essential services
- Public/private structures ⇨ competing imperatives, risks to affordability
  - Regulation of markets or revive public ownership?
- **We need** integrated urban planning & infrastructure policy ⇨ universal access to healthy and sustainable urban environments
- **But**… lack of necessary ideas, structures and processes:
  1. Federal – State - Local divisions of resources and responsibility
  2. Siloed State agencies – planning , transport, health, housing
  3. Loss of public leadership for public good in favour of 'facilitating' private sector
  4. Obsession with road transport
- GSC – City deals: a mechanism to address 1 and 2:
  - distribution of investment
- But lack of public leadership for public good remains

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THE UNIVERSITY OF SYDNEY

CRE HEALTH EQUITY

SESSION 2
Globalisation: Trade and Work

Session Chair:

Ross Womersley
Chief Executive Officer
SA Council of Social Services

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NHMRC Centre for Research Excellence
in the Social Determinants of Health Equity

Trade and Health:
Lessons in agenda-setting and evaluation

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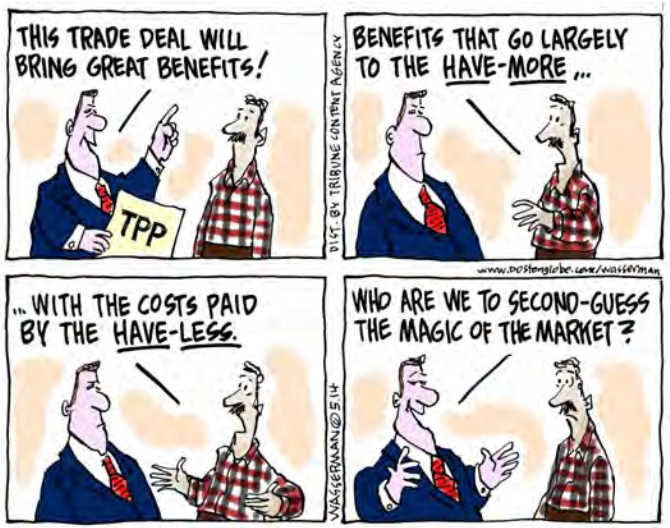
Trade and health equity:

lessons in agenda-setting and evaluation



Leads: Dr Ashley Schram & Dr Belinda Townsend

PIs: Prof Sharon Friel & Prof Fran Baum

CI: Prof Ronald Labonté

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Outline

- Why trade policy?
- What did we learn?
- Ways forward?

Why trade policy?

corporate profits and exploiting the planet ←  → sustainable equitable global development

conspicuous consumers ←  → conscious citizens

enhancing medicines monopolies ←  → sharing best available care

race to the bottom ←  → raising standards

What questions did we ask?

- how do we build evidence for health effects of trade?
- how do different actors frame trade policy interests?
  - what does this mean for health and health equity?
- how do strategies differ between market actors and public interest actors?
- how did medicines/tobacco become a trade issue?
  - will this work for alcohol, nutrition or public health more broadly?

Key findings: evidence (alcohol – econometric analysis)

Low Levels of Alcohol Abstinence

< 50% alcohol abstinence

- Chile
- China
- Japan
- Korea
- Laos
- New Zealand
- Philippines
- Singapore
- United States

High Levels of Alcohol Abstinence

≥ 50% alcohol abstinence

- Brunei
- Cambodia
- Indonesia
- Malaysia
- Myanmar
- Thailand
- Vietnam

Australian exports to 16 countries with a PTA

Tariff rates and export volumes on alcohol products

~ 7,000 observations (country, product, 1988-2016)

Time series analysis and gravity modelling (econometric analysis)

Key findings: evidence (alcohol – econometric analysis)

Variables	Share of Imports	Some Imports	Share (given some imports)
PTA	0.45**	0.067**	0.34
GDP	1.25***	0.22***	3.01***
Exchange Rate	-0.0018	-0.0022	1.730***
Tariff Rate	-0.042**	-0.011***	-0.017

New agreements between Australia and partners increase alcohol exports overall – but primarily through trade in new products

Variables	High Abstainers	Low Abstainers
PTA	1.14**	-0.033
GDP	1.56**	1.08**
Exchange Rate	-0.32**	0.24**
Tariff Rate	-0.19***	-0.016**

Effects of new agreements and tariff rate reductions stronger in countries with higher rates of alcohol abstinence

Key findings: framing

a set of values, morals, preferences and prejudices used to influence how people process information – i.e. how to think about an issue

- dominant frame: neoliberal market
  - markets operated by self-interested rational actors are the most effective mechanism to advance society and promote human wellbeing
- counter frame: state sovereignty
  - sovereign right of the state to strong and precautionary laws and regulations across health, environment, social protection and culture
- counter frame: public interest
  - private market interests should not compromise the provision of public goods and services, government must play a role in ensuring “a fair go for all”

Key findings: strategies

appeals to different sources of authority in attempt to assert their 'legitimacy' as actors who should be listened to by government

- **Networked** authority: claim shared beliefs/concerns with other actors
  - Power in numbers
- **Institutional** authority: claim positions of influence in recognised institutions
  - I am someone important
- **Legal** authority: cite legal texts or findings that support argument
  - The law is on my side
- **Expert** authority: cite expert evidence and data to support argument
  - I have evidence to back this up

dominant frame

vs

counter frame

Key findings: issues

	Frame Alignment	Path Dependencies	Treaties/ Legislation	Evidence Strength	Limited Exports	Exogenous Events
	✓	✓	✓	✓	✓	✓
			✓	✓	✓	✓
				?		?
	?			?	?	?

Ways Forward

Future research

- Investigating the efficacy of different frames and forms of authority
- Expanding the empirical evidence base of health outcomes

Advocacy lessons

- Need to socialise a broader range of health issues in trade policy
- Commitment to public interest frames
- Value of expanding and strengthening networks of health actors engaged in trade

Policy asks

- Health Equity Impact Assessments before agreements are signed
- Special considerations for health harmful products as non-ordinary commodities
  - tobacco, alcohol, ultra-processed food products

QUESTIONS?

NHMRC Centre for Research Excellence
in the Social Determinants of Health Equity

Work in a De-industrialised World:
De–industrialisation implications for health equity

Dr Kathryn Browne-Yung
Flinders University
#CREHealthEquity

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Work in a De-industrialised World: implications for health equity

Case Study:

How the policy response to the General Motors Holden closure influenced health equity for the Playford community.

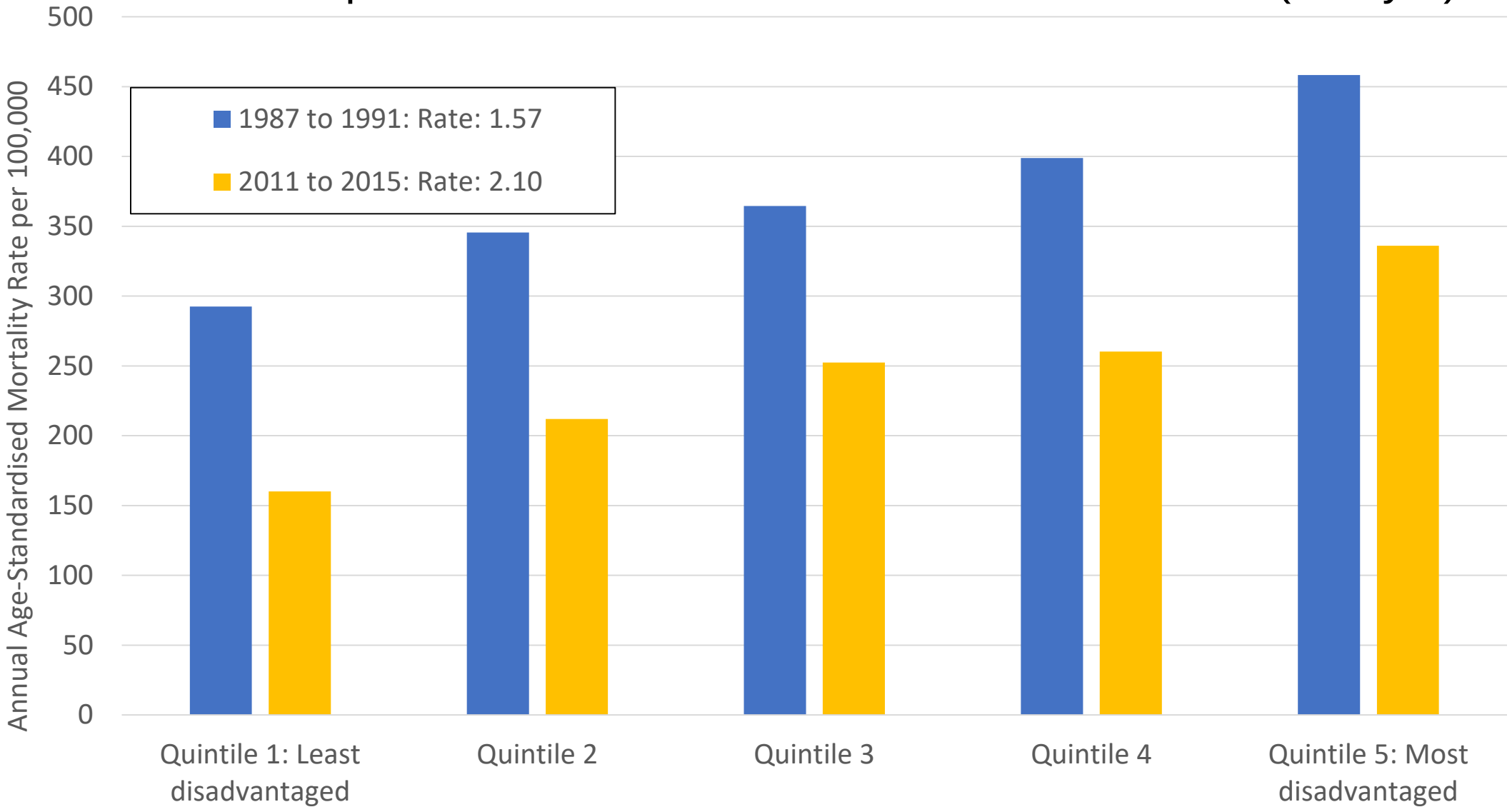
Research Team: Kathryn Browne-Yung, Anna Ziersch, Fran Baum, Sharon Friel & John Spoehr.

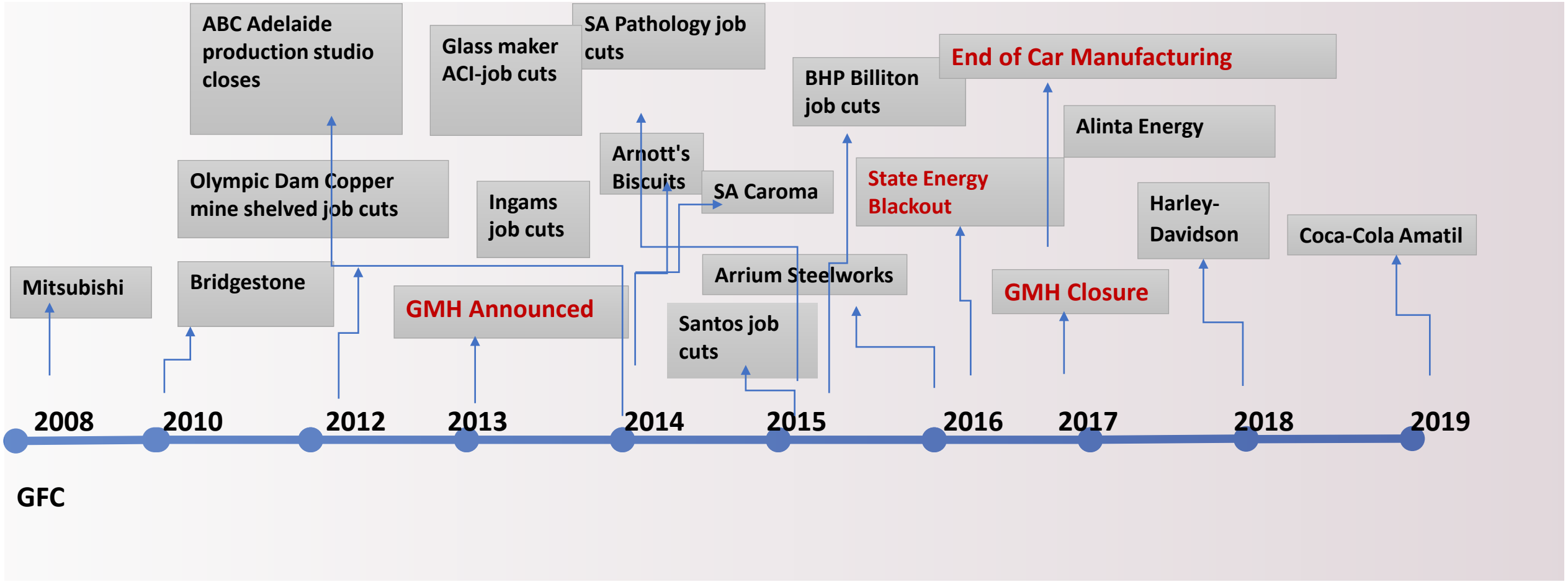
NHMRC *Centre of Research Excellence on the Social Determinants of Health Equity*

Presentation Outline

- Background: South Australia
- Case Study: Playford
- Methods: What we did
- Key Findings
- Discussion points

Health Inequalities in South Australia: Premature Deaths (0-74yrs)





South Australia: Major Employer job cuts & closures 2008-2019

General Motors Holden job loss

- Economic modelling
  - loss of $1,24 billion
  - 13,200 jobs (Burgan & Spoehr 2013)

- Supply chain business
  - Tier 1 = 33 businesses (3,700)
  - Tiers 2-4 = 719

- 2013 closure announced in 2017
  - 2013- 1,600 GMH employees
  - 2017- 900 GMH employees
  - Expected job loss 6,000

Case Study: Playford

ABS (2017) Community Profiles; ABS (2019) LGA Data Tables Small Area Labour Market March Quarter 2019, Cat No 6202.0; PHIDU (2019) Social Health Atlas of Australia: South Australia by LGA .

	Playford 93,426	Greater Adelaide	South Australia	Australia
Aboriginal and Torres Strait Islander Residents	3.5%	1.4%	2%	2.8%
Median Age	32	39	40	38
Workforce participation	54%	59%	58%	60%
Unemployment	13.25%	6.8%	6.9%	5.2%
Youth	18-25%	----------	12%	12%
Underemployed	----------	----------	16%	13%
Welfare dependent families with children	23 %	9.2 %	9.6 %	9 %
Children low income welfare dependent families	45.3%	23%	25%	20.9%
SEIFA	855	989	979	1002

Research Methods (2015-2018)

1. 2015-2018 Analysis of South Australian government policy response to GMH closure

   Bacchi WPR (*What's the problem represented to be*) Problematisation

2. 2016 Workshops: Systems Thinking Approach

3. 2017-2018: 31 In-depth interviews

Timeline Policy response to GMH closure

2013 | 2014 | 2015 | 2016 | 2017 | 2018

Federal

Automotive Transformation Scheme

Industry Growth Fund →

State

Automotive Transformation Taskforce (ATT) →

ADELAIDE SOUTH AUSTRALIA

Our Jobs Plan

10 Economic Priorities

Northern Economic Plan

Local

Playford Community Vision 2043

Health/Sports Precinct

Key findings analysis policy response

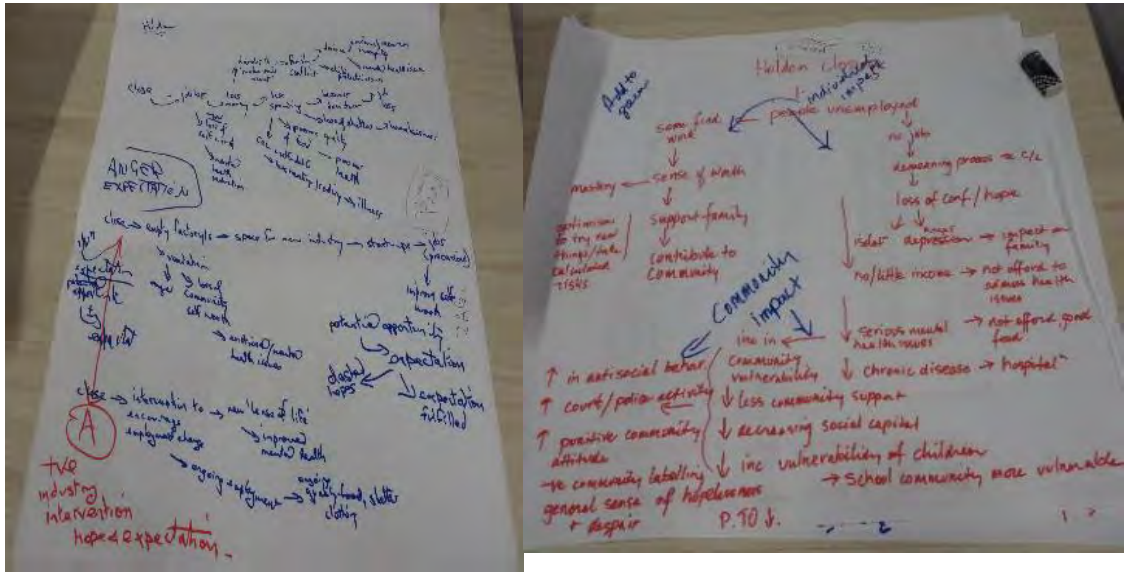
- Narrow policy frame - Jobs and diversification
- Economic focus – absence of social and health equity
- Job creation - target groups
- Community programs already in place
- Governance - top down
- Federal policy response – programmatic

Systems Thinking

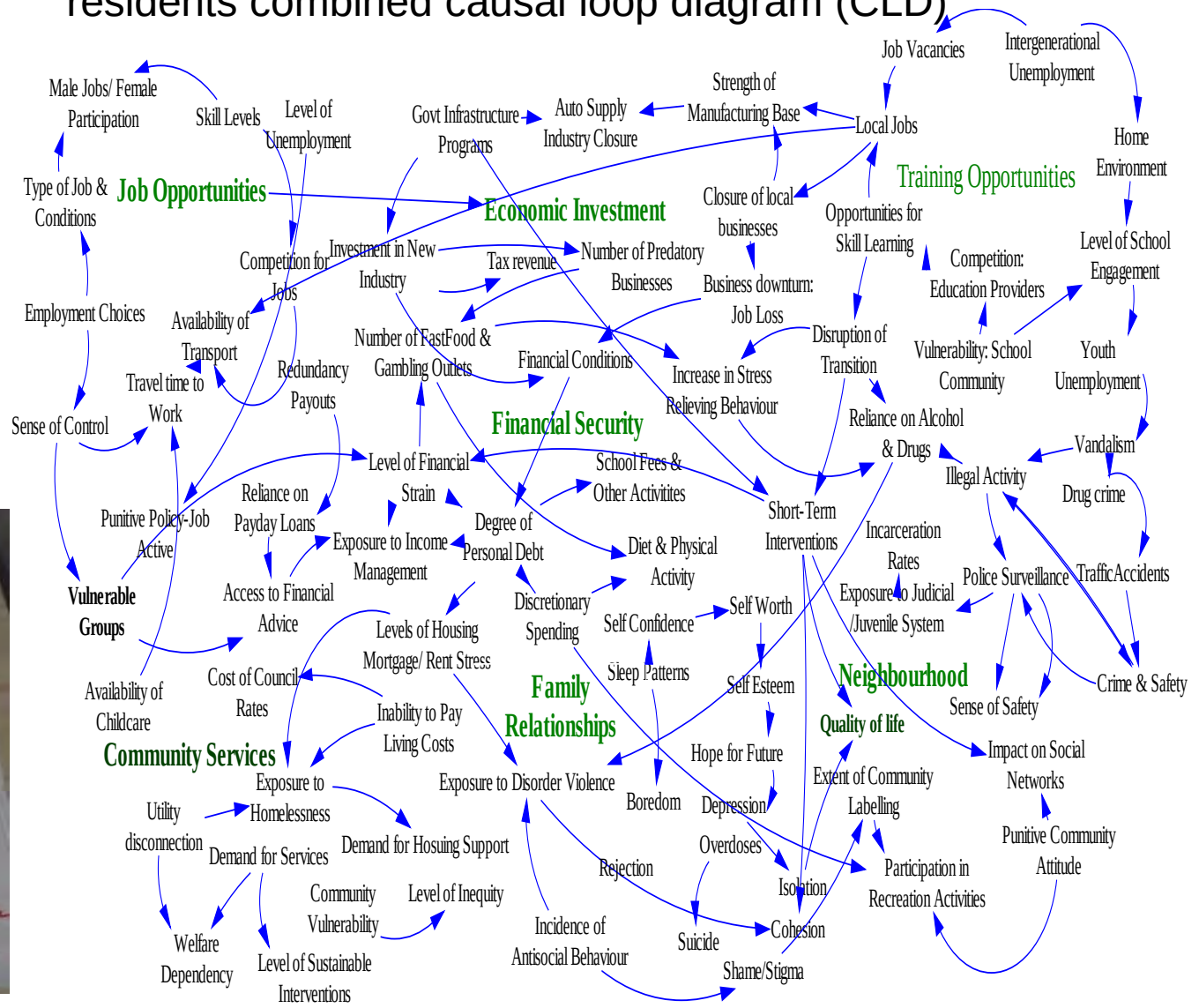
Coproduction : Conceptual Maps

Three Workshops:

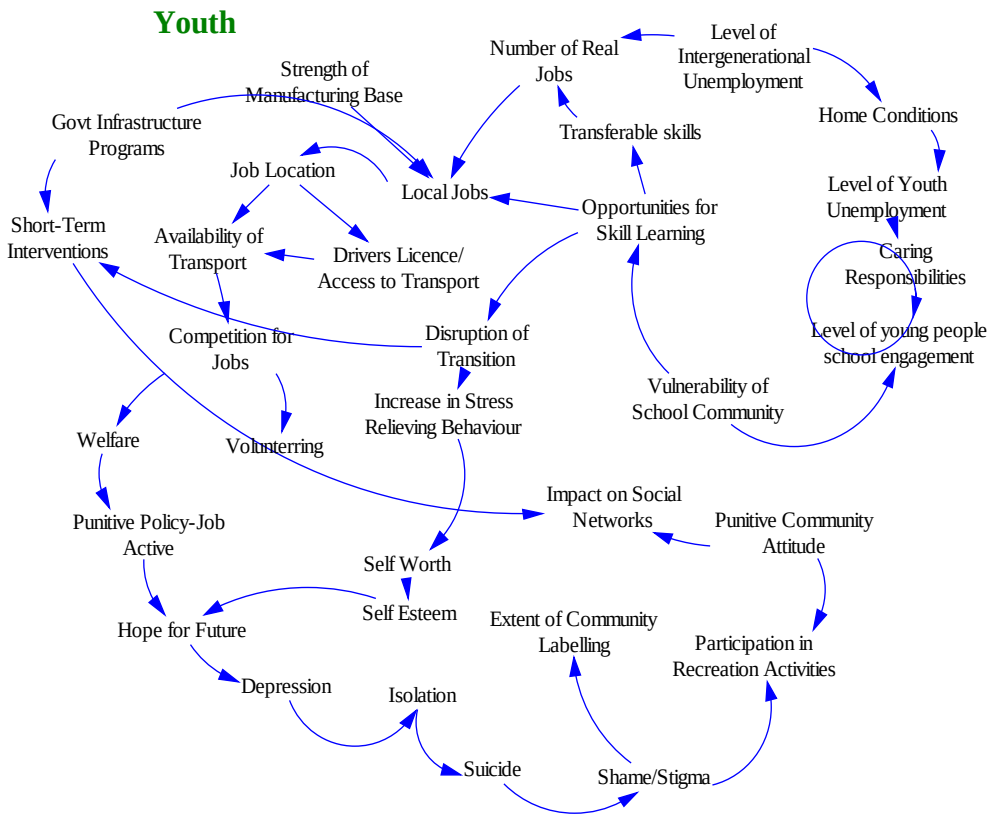
- Two Policy & Community service stakeholder N=28
- One Community residents n=14



Policy, community service providers and residents combined causal loop diagram (CLD)



Youth employment pathways subset of elements combined policy, community service providers & residents CLD



- Intergenerational
- Home conditions
- Youth Unemployment
- Caring Responsibilities
- Engagement
- Vulnerability in School
- Skills training-transferability
- Job quality- cdns
- Own transport –local jobs
- Welfare / Volunteering
- Poverty
- Hope for the future

In- depth Interviews N=31

Recruitment:

- invitation through community & professional networks
- snowballing technique

Sample:

Policy and Community service providers:

- State Policy stakeholders (N=3)
- Local government (N=3) community services (N=2)
- Non-government agencies (N=3).
- Automotive Taskforce (N=5).

Community Residents:

- Retirees, ex GMH workers, local workers, and people currently unemployed (N=9).
- Youth residents aged 18-24 (N=6)

Procedure:

- Face to face or telephone
- Audiotaped & transcribed

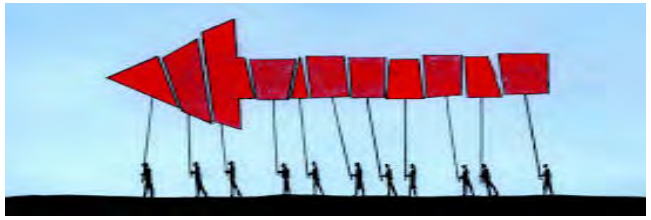
Data Analysis

- Thematic analysis

Key conditions for health equity: Policy Vision

Narrowly defined policy problem

”Our strict measure is jobs” (State policy stakeholder)



Community based Interventions -ad hoc reactive

“*We have just got to be nimble or have a three-month plan and then we will react. I think we will end up with the traditional stuff around family breakdowns and the mental health issues”(State policy stakeholder)*

“*I do think that some of the policy response items were already happening, rebadged a bit, when they were already happening regardless (Community service provider)*

Short-term and long-term visions incompatible

“The issue isn't necessarily about the policy that's implemented or the policy response, it's about the ongoing policy effects … the broader context of now that Holden is on the front page of the paper every day, what is your longer term policy response what is your longer-term policy response, will it just die a natural death because it's not causing political pain”. (Local government stakeholder)

Key conditions for health equity: Collaboration

Collaboration between local and state government

“Are we better off with something owned by the region where state governments are supportive, not necessarily the driver? Currently that allows councils to sit on the sidelines a little bit and say, well state government, this is your project, you make this happen”. (State government stakeholder)

Collaboration between local government sectors

“There is a desire to try and integrate the public health plan with the strategic plan…And the whole idea of health in all policies -now you have got a separate health plan. All the things that councils do is about health and it’s all about our strategic plan” (Local government stakeholder)

Nature of funding arrangements

“Because of the way that the funding is set up, we're all competing against each other, which then means that we don't talk to each other” (Community service provider)

Key conditions for health equity: Collaboration

Cross Sectoral collaboration

"The interface between education, child protection, and youth-orientated labour market and youth health programs could be strengthened as a policy area. They're often treated very distinctly" (Community service provider)

Northern Connections hub for collaboration

"One state government initiative, probably under-valued, was Northern Connections (Office of the North). It delivers an intelligence network for the community. Lots of people have a lot of ideas about what should happen in the north, and they make the decisions, but they' do not necessarily ever come here, and Northern Connections being here is important"(Community service provider).

Key conditions for health equity : *Political Events*

- Closure of Automotive Industry
- Short- term electoral cycles
- New State Government

“Once you get a change of government, the dynamics change[Playford] is lower socio area and a Labor area”. (Community resident)

“Anything that was Labor will no longer be in play, and after 16 years everything virtually has Labour written on it so it will all go” (State government stakeholder)

“They’ve never bothered to put money in this area in the past when they’ve been in, not a penny.” (Community resident)

Auto Workers:

2018 One-year post plant closure

75% GMH - some work
35-40% working fulltime

Job quality

Average 2-3 jobs

Supply chain workers:

- 1,800 looking for work
- 48% over 50 yrs

Employed 181 = 55.9%

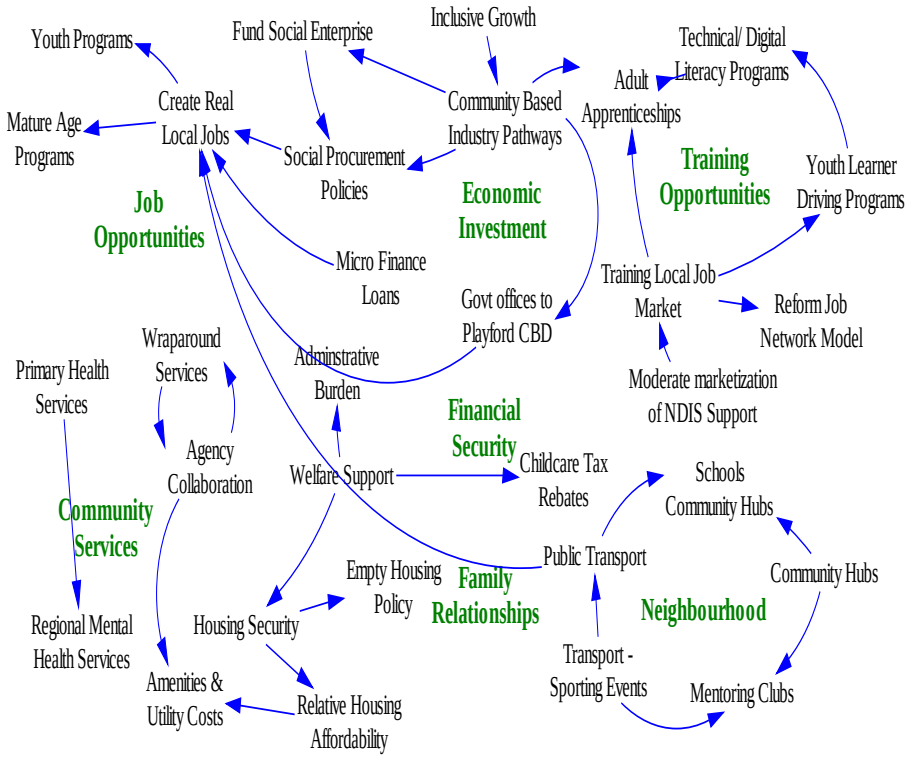
Full-time 31 = 17.1%
Part-time 13 = 7.2%
Casual 84 = 46.4%
Contract 30 = 16.6%
Self employed 23 = 12.7%

Unemployed training or study 143= 44%

N=324

Job Churn - *"Automotive workers get a job, leave that job, get another job, leave that job. Some of them, up to their third job already" (Auto Transformation Support)*

Policy suggestions for social & health equity …



- Training
- Neighbourhood
- Economic
- Community

Discussion Points

How do we ensure

- that the nature and conditions of employment promote health equity
- that social and health equity are explicit in policy formulation
- collaboration between levels of government and across sectors

How do we maintain political commitment for equitable policies ?

What have we done by Peter Rufus (ex GMH worker)

Those in power
Their plans so staid
With no care
The call was made.
We'll not listen
To the endless fuss
No more money
Will come from us.
Ships of war
We want to build
Be so grateful
They use your skill.
Will they say
When the bad times come
Oh my God
What have we done?

Those obliged
With telling the mob
Made it sound
Such a hopeless job.
What a waste
Of money on them
Your taxes
They can better spend.
Then they all
Became our mates
Told the world
Of our awful fates.
Will this lament
Come from their tongue
Oh my God
What have we done?

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in the Social Determinants of Health Equity

Informal Work

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Informal Work in Australia:

Implications for health

Miriam Vandenberg

Southgate Institute for Health, Society & Equity, Flinders University, South Australia

Promoting Health Equity: From Knowing to Action, Centre for Research Excellence in the Social Determinants of Health Equity Symposium 2019, South Australia

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Southgate Institute for Health, Society & Equity

Precarious employment is rising rapidly among men: new research

Curtin University 13 April 2018

Insecure work the 'new norm' as full-time job rate hits record low: report

ABC 7 June 2018

One Year After Holden Closure, Job Outlook Worsening

Anglicare SA 18 October 2018

June 19, 2019 is the 50th anniversary of Australia's industrial relations system endorsing the principle of "equal pay for equal work". Yet, five decades on, a gender pay gap remains.

The Conversation 19 June 2019

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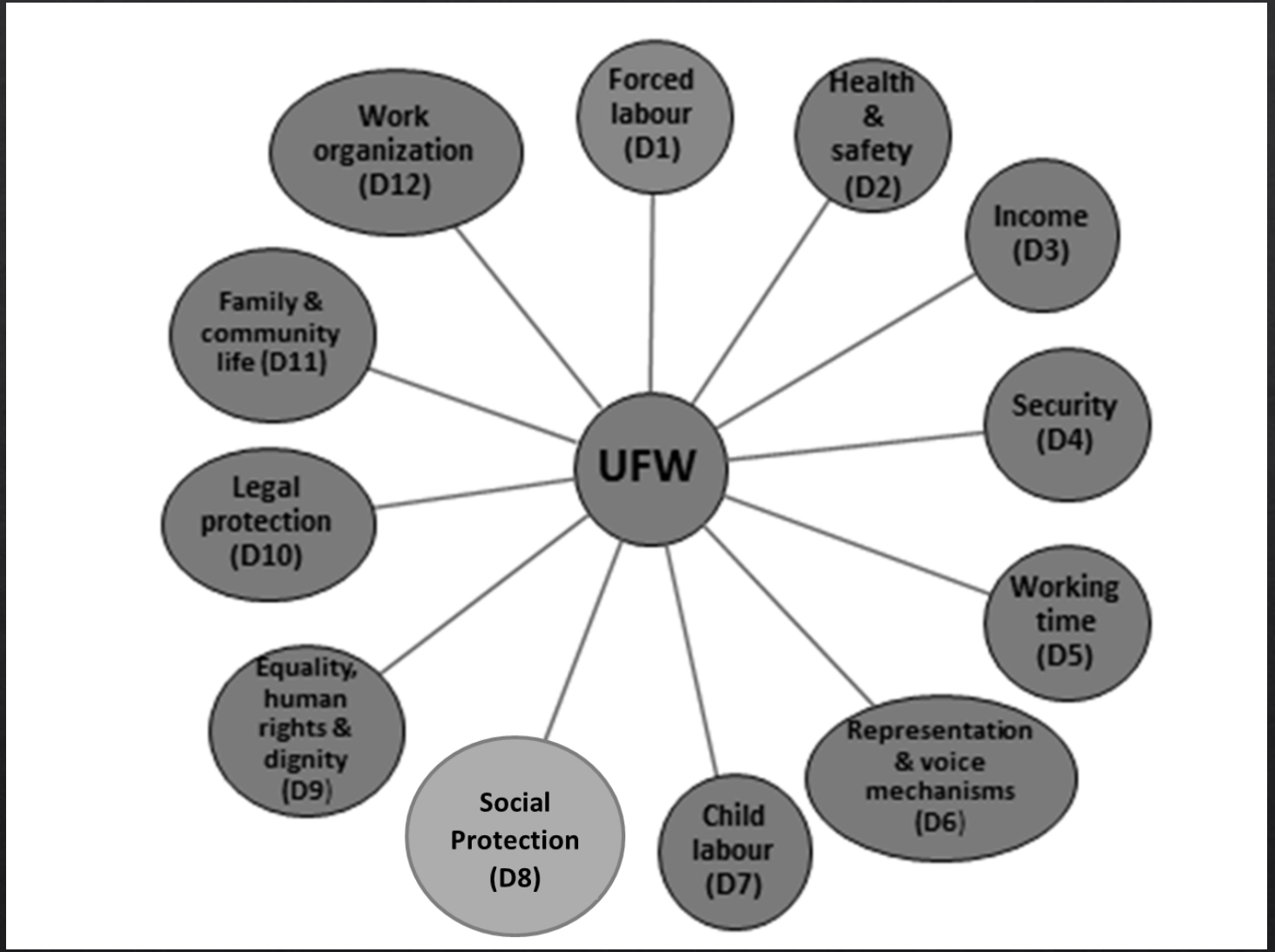
Why this matters

Unacceptable forms of work (UFW) are described as comprising conditions that deny fundamental principles and rights at work, put at risk the lives, health, freedom, human dignity and security of workers or keep households in conditions of poverty.

(Fudge & McCann, 2015, ILO)



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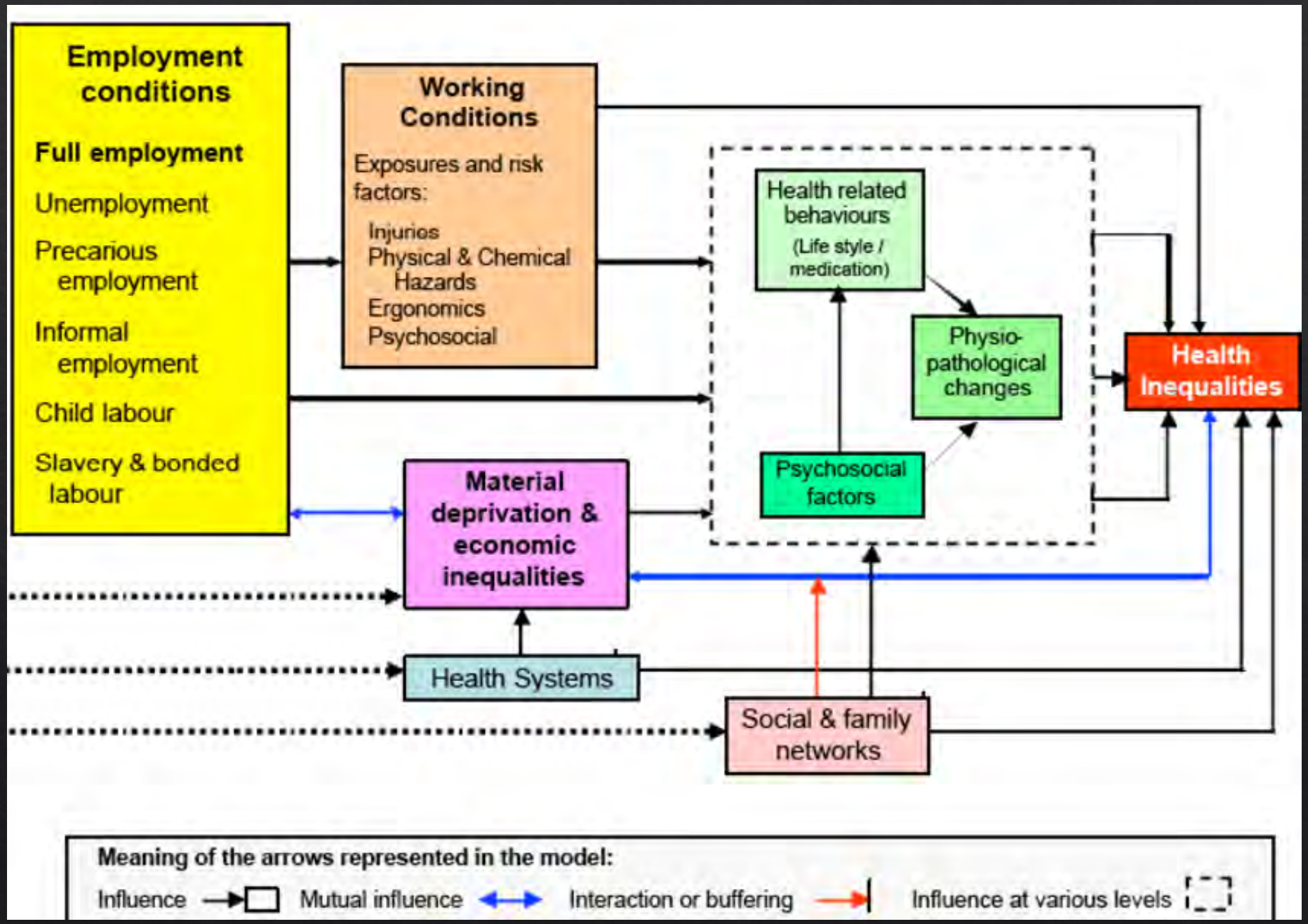

Micro-theoretical framework of employment conditions and health inequalities
(Benach et al 2006)

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Informal work

- Informal employment is characterised by non-regulated placement in the labour market
- Two billion people are employed in the informal economy around the world (ILO 2018)
- The estimated size of the informal economy in Australia ranges from 1.5% of GDP (ABS 2013) to 14.1% of GDP (Medina & Schneider 2017)
- The Australian Government established a Black Economy Taskforce in 2016 to ‘tackle’ this “significant, pervasive, damaging and growing economic and social phenomenon” (COA 2017, p. 11)

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A study of the health of informal workers in South Australia

To explore Australian informal workers' experiences of informal employment through a social determinants of health lens, and to understand informal workers' perceptions about the health effects of their involvement in the informal sector.

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Informal work in Australia

- Informal employment is a feature of the labour market in high income countries
- Push and pull factors
- Across the social hierarchy
- Wide range of occupations
- Intertwined with precarious lives
- Unfair and indecent employment and workplace conditions and power relations

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Informal work: Occupations

- Construction and labouring, gardening and home maintenance, hospitality, retail, arts, agriculture, childcare, wellbeing (physical activity, massage, beauty), information technology, body piercing, domestic cleaning, recycling, entertainment, driving and delivery (advertising material, furniture removal, freight)
- Employer/employee and self-employed

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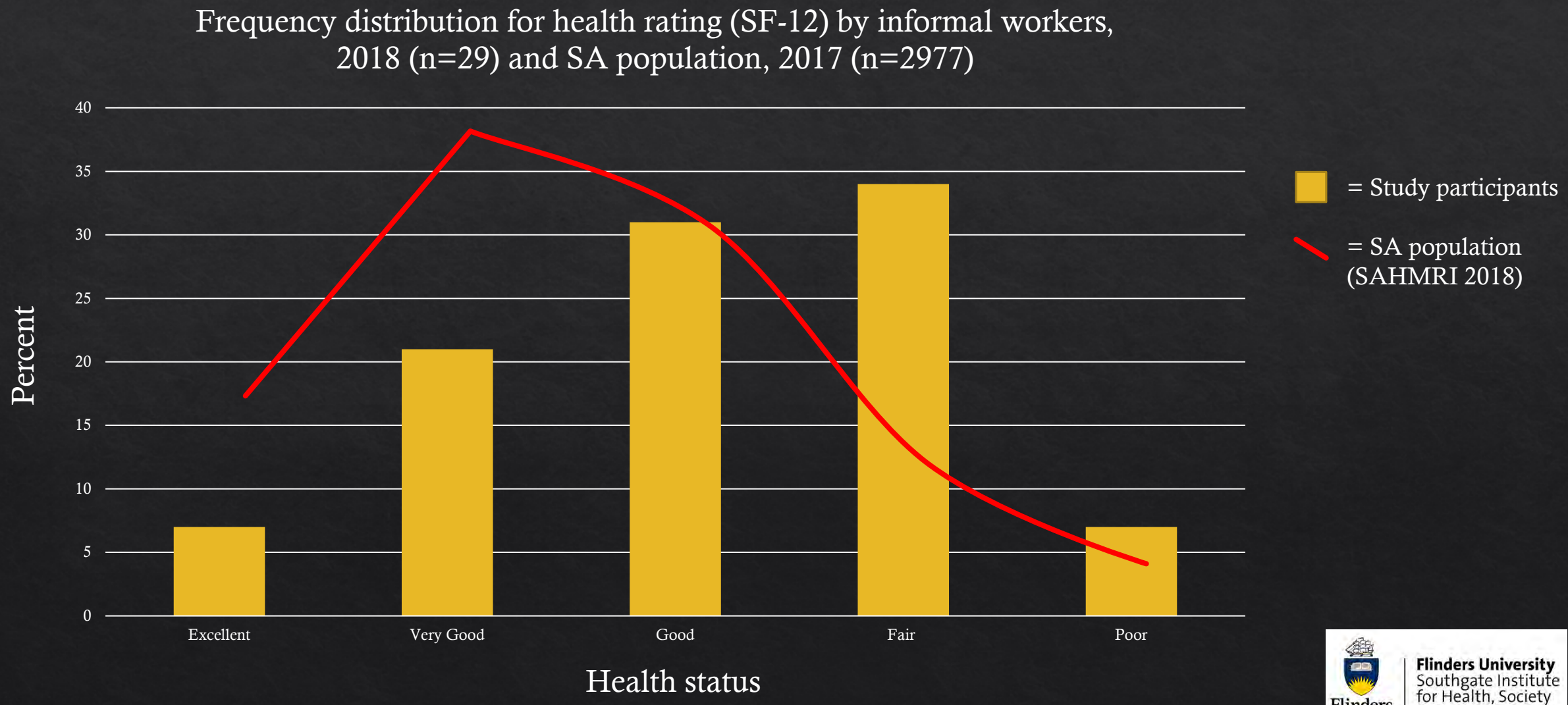
Self-reported health status of informal workers



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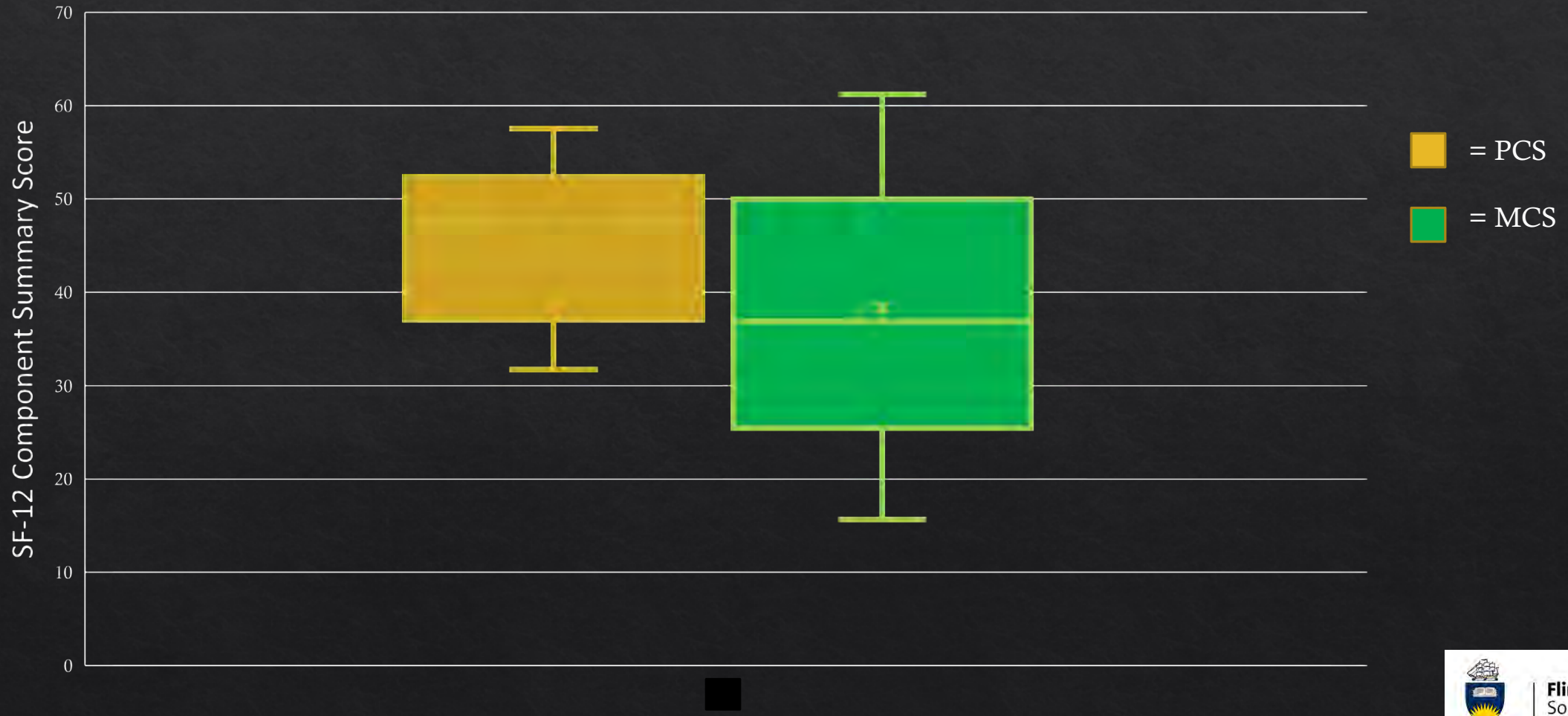
Physical & mental health scores

Mean SF-12 Physical (PCS) and Mental Component Summary (MCS) scores for informal workers (n=29)



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Informal workplace conditions

Physical	Chemical	Ergonomic	Psychosocial
Asbestos dust	Cleaning chemicals	Long hours	Invisibility
Clay dust	Horticultural chemicals	Prolonged standing/walking/running or static positions	Job insecurity
Sun and heat exposure		Lack of breaks	Not paying tax
Loud noise			Low pay and lack of entitlements
Sharp objects			Unfair power relations
Construction materials			Irregular work hours
Heavy objects			Misrepresenting work activities
Heights			Violence
Workplace equipment (e.g. sewing machine, hot appliances)			
Violence and physical encounters			
Contaminated waste			
Biological matter			

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Perceptions about how informal employment effects health

Physical Health	Mental Health and Social Wellbeing
Back, shoulder, neck and knee pain (in some cases, arthritis) and other bodily pain	Anger issues (intermittent explosive disorder)
Breathlessness (associated with anxiety)	Anxiety
Concussion	Depression
Electric shocks to the body	Isolation
Enuresis /encopresis	Mental distress
Eye irritation	Night terrors
Fatigue	
Foot pain and plantar fasciitis	
Headache (sometimes associated with mental distress)	
Hearing loss	
Hyperactivity and insomnia (sometimes associated with mental distress)	
Inhalation of hazardous substances (e.g. asbestos, clay dust)	
Joint dislocation	
Puncture wounds, cuts and burns	
Skin and eye irritation	
Sprains, torn muscles, sciatica and bruising	

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Conclusion

The challenge for society and governments is how to create fair and decent opportunities for work for all Australians in the face of the rapidly changing labour landscape

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in the Social Determinants of Health Equity

Paid Parental Leave

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Australian National University

Agenda setting for paid parental leave in Australia

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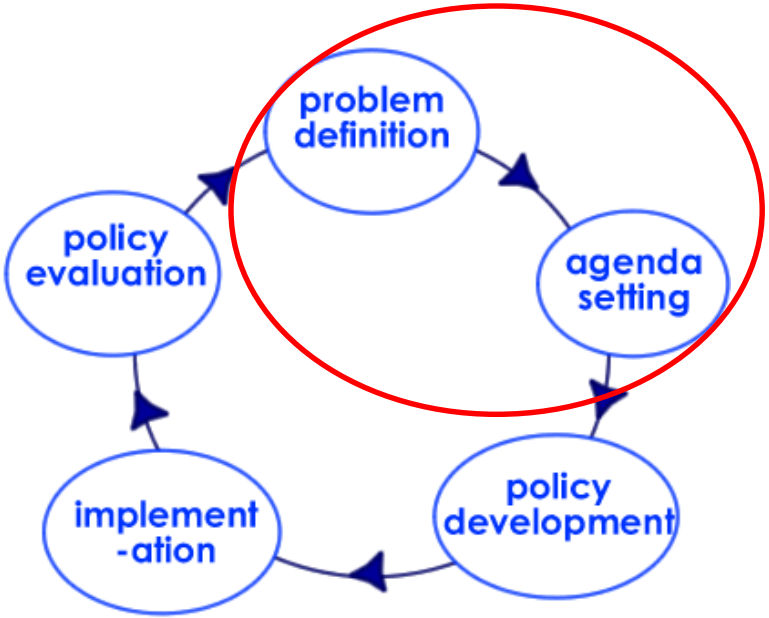
CRE HEALTH EQUITY

How can we make health equity a political and policy concern of government?



Paid parental leave in Australia

Australia's PPL scheme announced in 2009, impl 2011:

- 18 weeks pay at minimum wage for primary caregiver
- Two weeks dad and partner pay at minimum wage added in 2013
- Voluntary employer funded PPL leave can be added

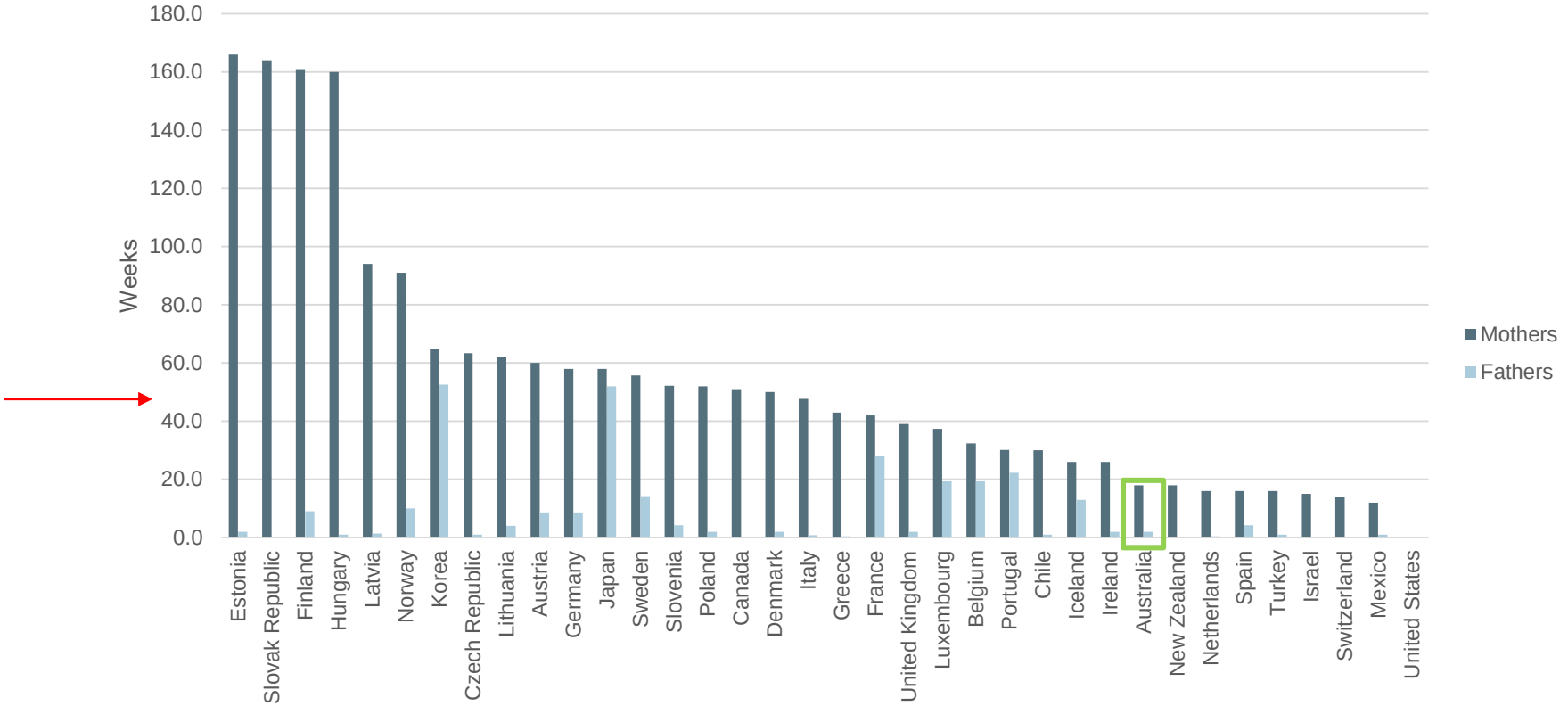
Three goals in legislation:

↑ Women's labour force participation and economic productivity

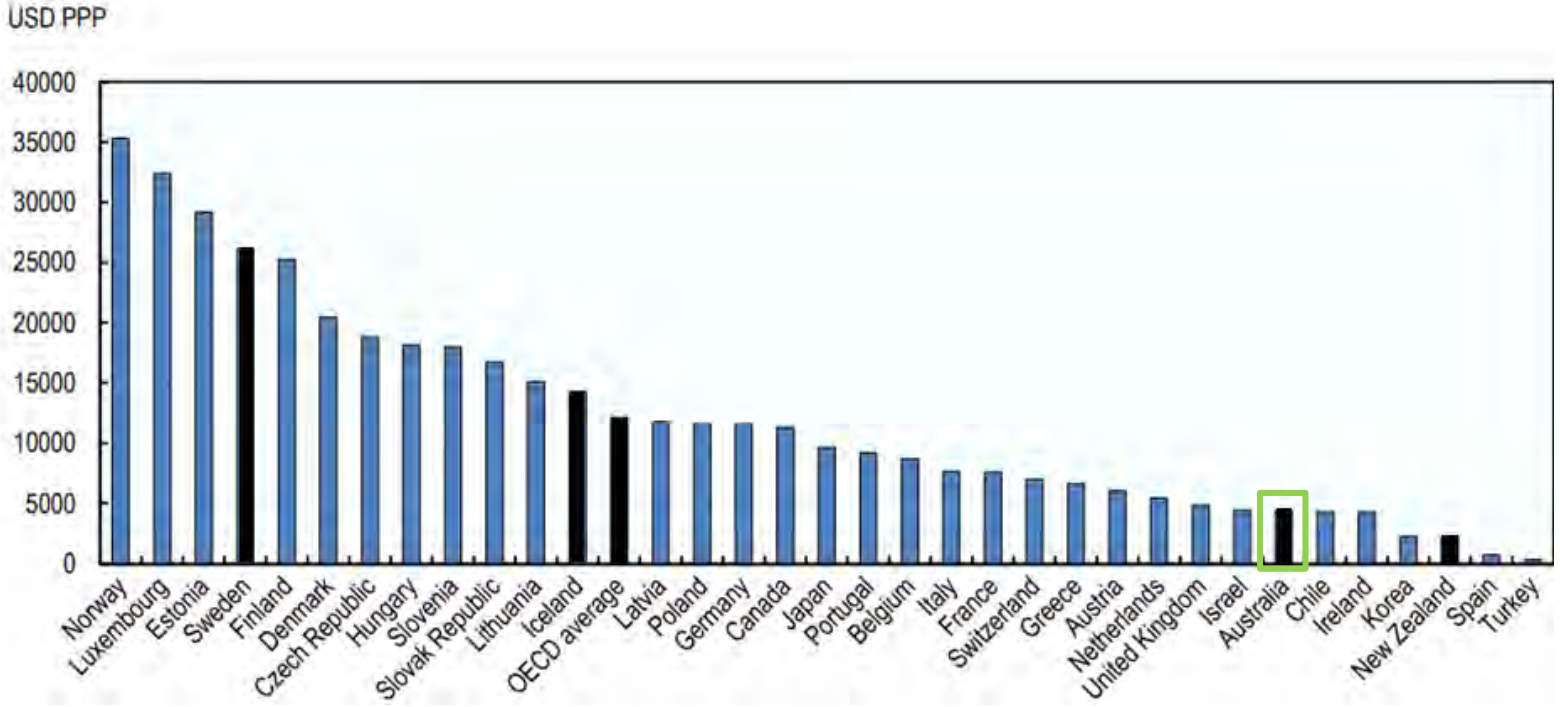
↑ Gender equality

↑ Health and wellbeing of babies and mothers

Total Paid Leave Available: Length (weeks)

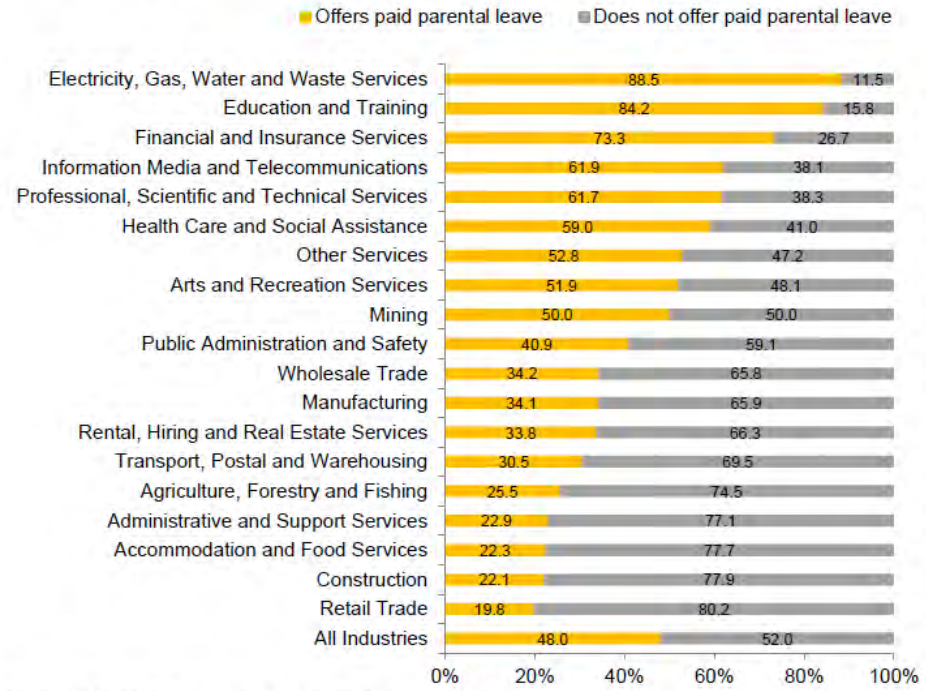


Public expenditure on maternity and parental leave (per live birth), 2015



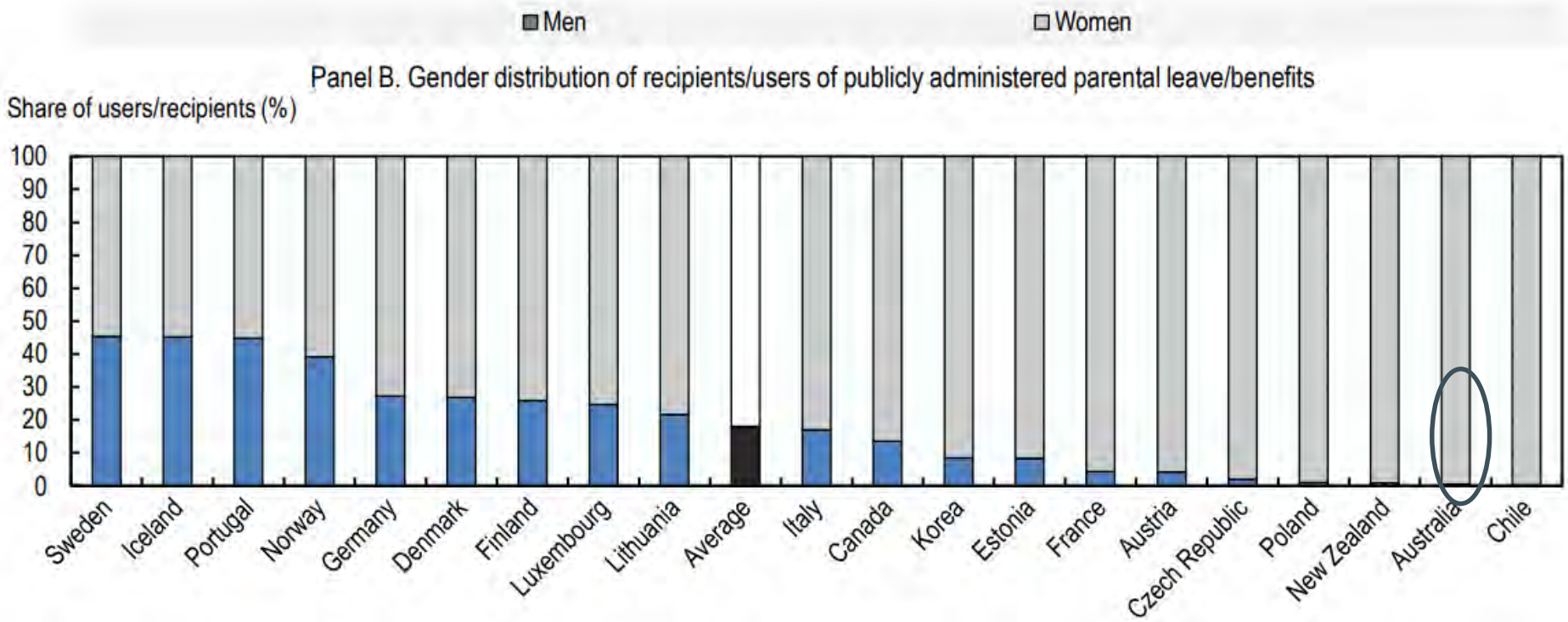
Industry/workplace inequality in PPL

Table 1: Proportion of organisations offering paid parental leave by industry 2015-16

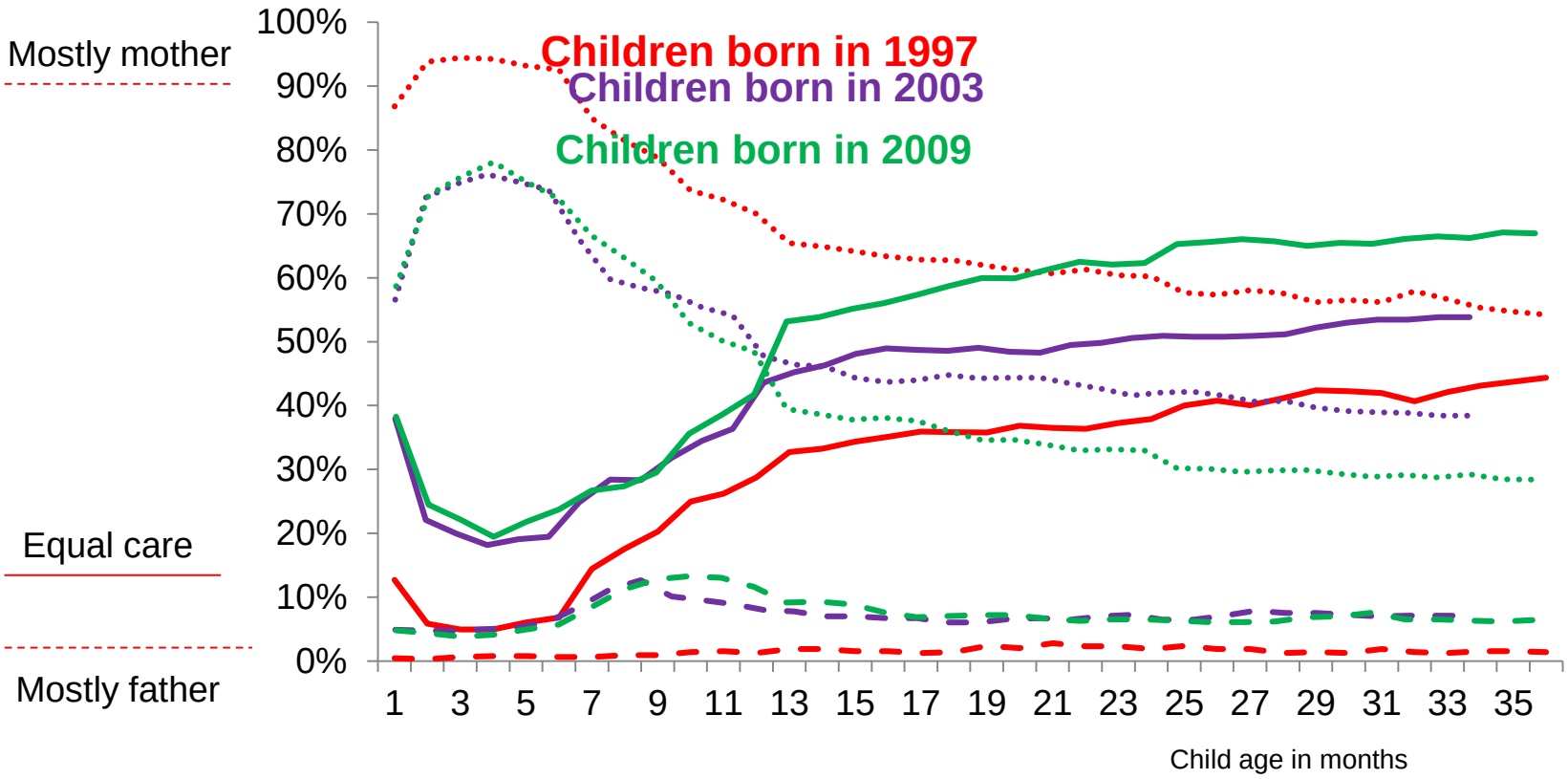


Source: WGEA (2016), Agency reporting data (2015-16 reporting period).

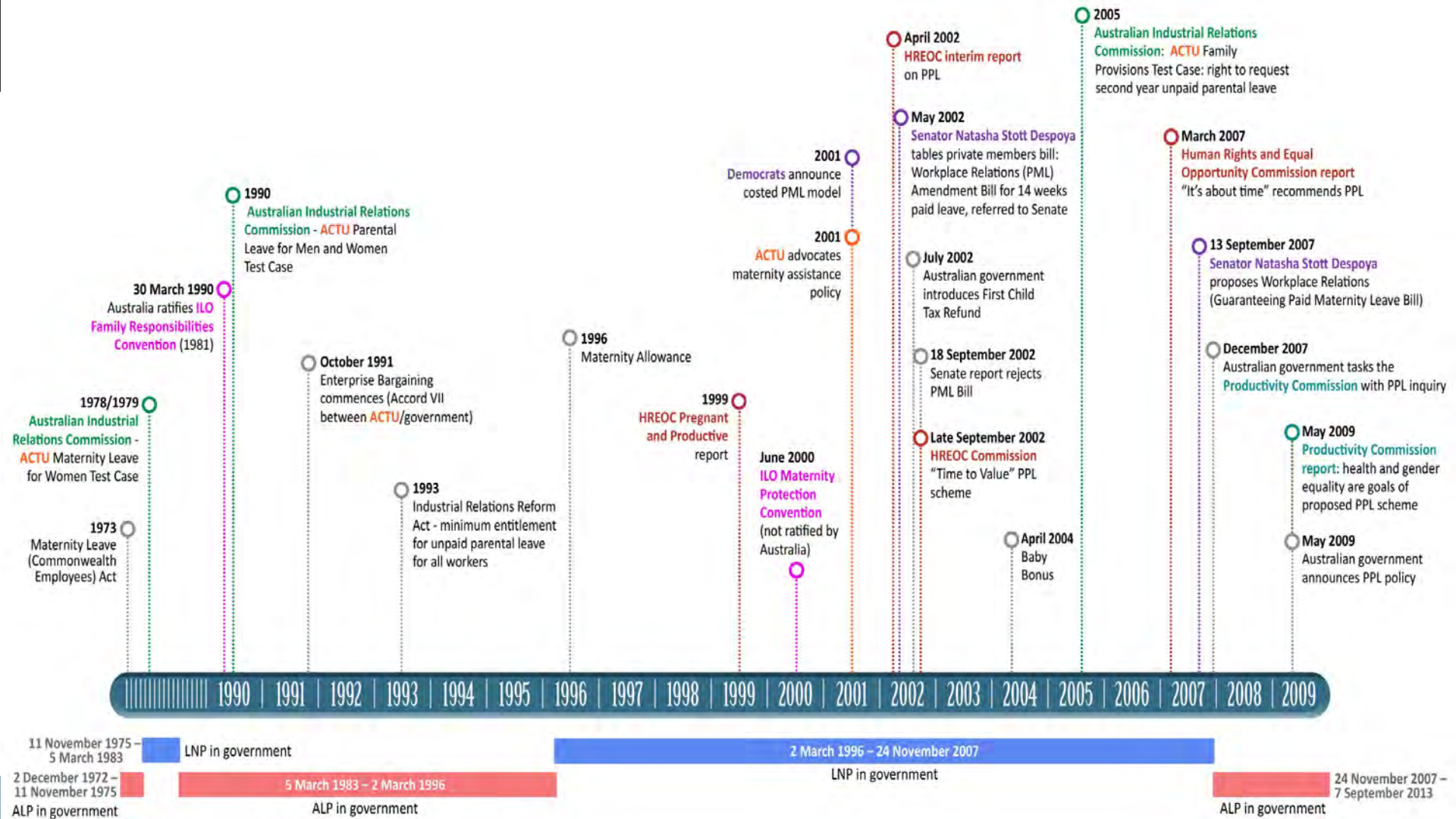
Fathers' and Partners' PPL



The Iceland example – what's possible



Arnalds, Eydal and Gislason. 2013. 'Equal rights to paid parental leave' *Icelandic Review of Politics and Administration*, 9(2).


1973
Maternity Leave (Commonwealth Employees) Act
1978/1979
Australian Industrial Relations Commission - ACTU Maternity Leave for Women Test Case
30 March 1990
Australia ratifies ILO Family Responsibilities Convention (1981)
1990
Australian Industrial Relations Commission - ACTU Parental Leave for Men and Women Test Case
October 1991
Enterprise Bargaining commences (Accord VII between ACTU/government)
1993
Industrial Relations Reform Act - minimum entitlement for unpaid parental leave for all workers
1996
Maternity Allowance
1999
HREOC Pregnant and Productive report
June 2000
ILO Maternity Protection Convention (not ratified by Australia)
2001
Democrats announce costed PML model
2001
ACTU advocates maternity assistance policy
April 2002
HREOC interim report on PPL
May 2002
Senator Natasha Stott Despoya tables private members bill: Workplace Relations (PML) Amendment Bill for 14 weeks paid leave, referred to Senate
July 2002
Australian government introduces First Child Tax Refund
18 September 2002
Senate report rejects PML Bill
Late September 2002
HREOC Commission "Time to Value" PPL scheme
April 2004
Baby Bonus
2005
Australian Industrial Relations Commission: ACTU Family Provisions Test Case: right to request second year unpaid parental leave
March 2007
Human Rights and Equal Opportunity Commission report "It's about time" recommends PPL
13 September 2007
Senator Natasha Stott Despoya proposes Workplace Relations (Guaranteeing Paid Maternity Leave Bill)
December 2007
Australian government tasks the Productivity Commission with PPL inquiry
May 2009
Productivity Commission report: health and gender equality are goals of proposed PPL scheme
May 2009
Australian government announces PPL policy
1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009
11 November 1975 – 5 March 1983
LNP in government
2 December 1972 – 11 November 1975
ALP in government
5 March 1983 – 2 March 1996
ALP in government
2 March 1996 – 24 November 2007
LNP in government
24 November 2007 – 7 September 2013
ALP in government

Two phases

1970s - 2000

- Paid parental leave fails to get onto agenda
- Fought in industrial relations arena
- Strong employer opposition to pay

2000 onwards

- Marks a shift in strategy and tactic by advocates
- Key shift to a government funded scheme with voluntary top ups from industry
- Advocacy leads to successful policy, implemented 2011

First phase: key barriers

- Gendered model of employment – the “wage-earner welfare state”
- Adversarial industrial relations system & employer opposition
- Conservative ideology
- Anti-welfare views
- Weak advocacy
- Lack of health evidence

Second phase: key enablers

- Shift in tactic to government-funded scheme
- Building broad coalitions
- Strategic framing
- Incremental approach
- Generating health evidence
- Shifting venue
- Election of ALP

Framing ideas

- All 3 frames (economics, health, gender) required to get PPL over the line
- Health uncontested but often not key frame
- Tensions between health and gender framing
- Equity was an underlying rationale but not seen as winning the debate
- Productivity and economic framing was powerful

Policy legacies and path dependency

- Australia's minimum scheme was always intended to be an incremental step

- Next steps for improving PPL – both tinkering and transformation

National roundtable on Next Steps for PPL, 22 August, ANU

Lessons from PPL ‘mark 1’?

- Broad informal coalition of supporters
- Different framing arguments
- Evidence collected
- Debates in different institutional venues

Acknowledgments

Prof Lyndall Strazdins, Prof Sharon Friel, Prof Fran Baum, Dr Phillip Baker.

NHMRC Centre for Research Excellence in the Social Determinants of Health Equity

@crehealthequity

@beltownsend

SESSION 3
Effective Policy to Close The Gap

Session Chair:

Professor Dennis McDermott
Pro-Vice Chancellor (Indigenous)
La Trobe University

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NHMRC Centre for Research Excellence
in the Social Determinants of Health Equity

Effective Policy to Close the Gap
Lessons from the NTER and CTG policy 2008-2018

Associate Professor Tamara Mackean ,Dr
Toby Freeman and Dr Matt Fisher
Flinders University
@drtobyfreeman

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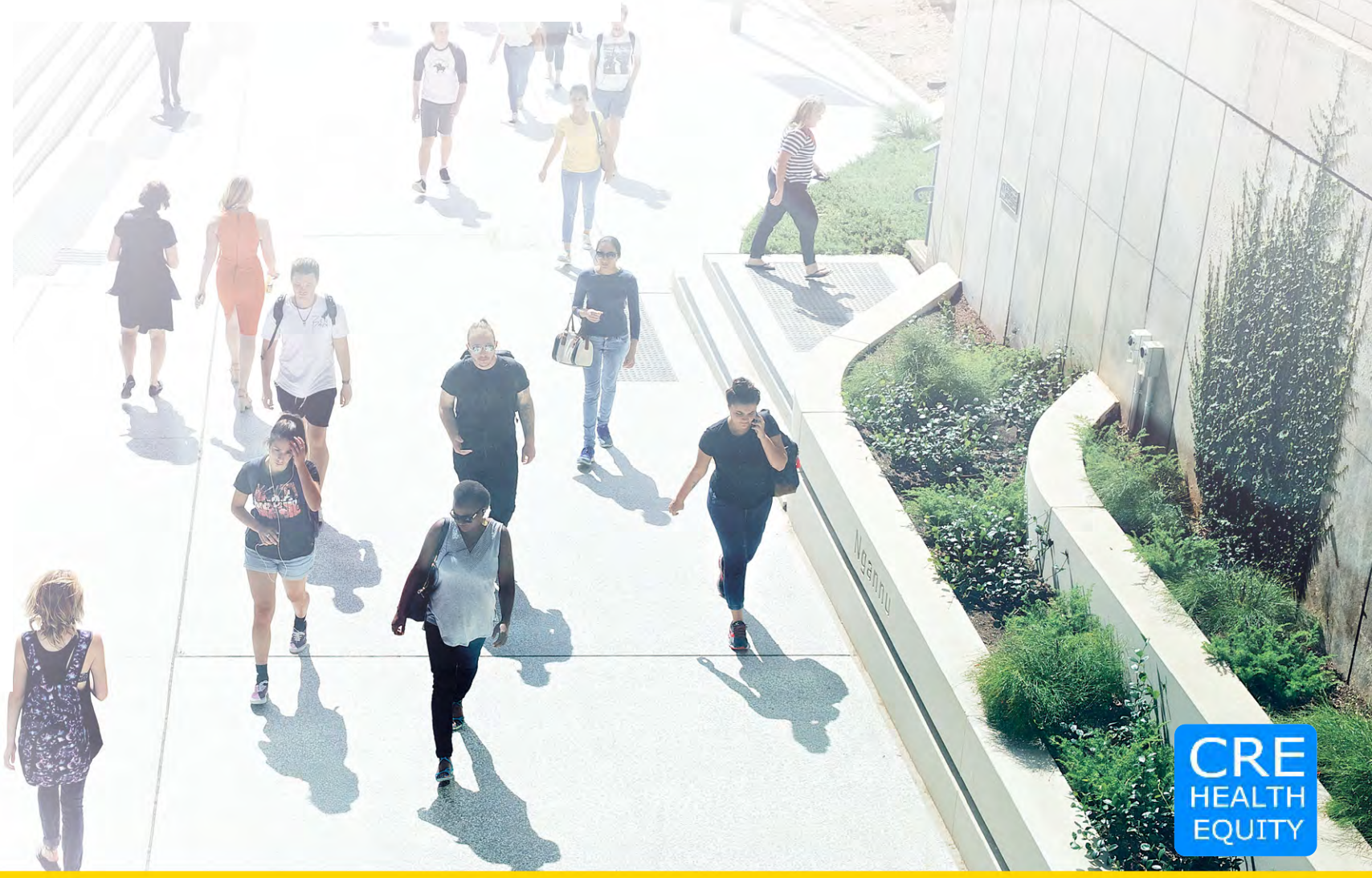
Effective Policy to Close the Gap

Lessons from the NTER and CTG policy 2008-2018

- Tamara Mackean
- Matt Fisher
- Toby Freeman
- Belinda Townsend
- Emma George
- Sharon Friel
- Fran Baum



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CRE research stream on Indigenous Peoples & health equity

Lead investigators: Assoc. Prof. Tamara Mackean and Prof. Dennis McDermott

Two case studies:

- Northern Territory Emergency Response 2007
  - Stream of work on agenda setting
- Case study of national Closing the Gap policy 2008 - 2018
  - Stream of work on implementation

Cross cutting work:

- Integrating Indigenous knowledges in research on public policy
  - Discussion paper & reflection tool
  - Framework to assess cultural safety in public policy

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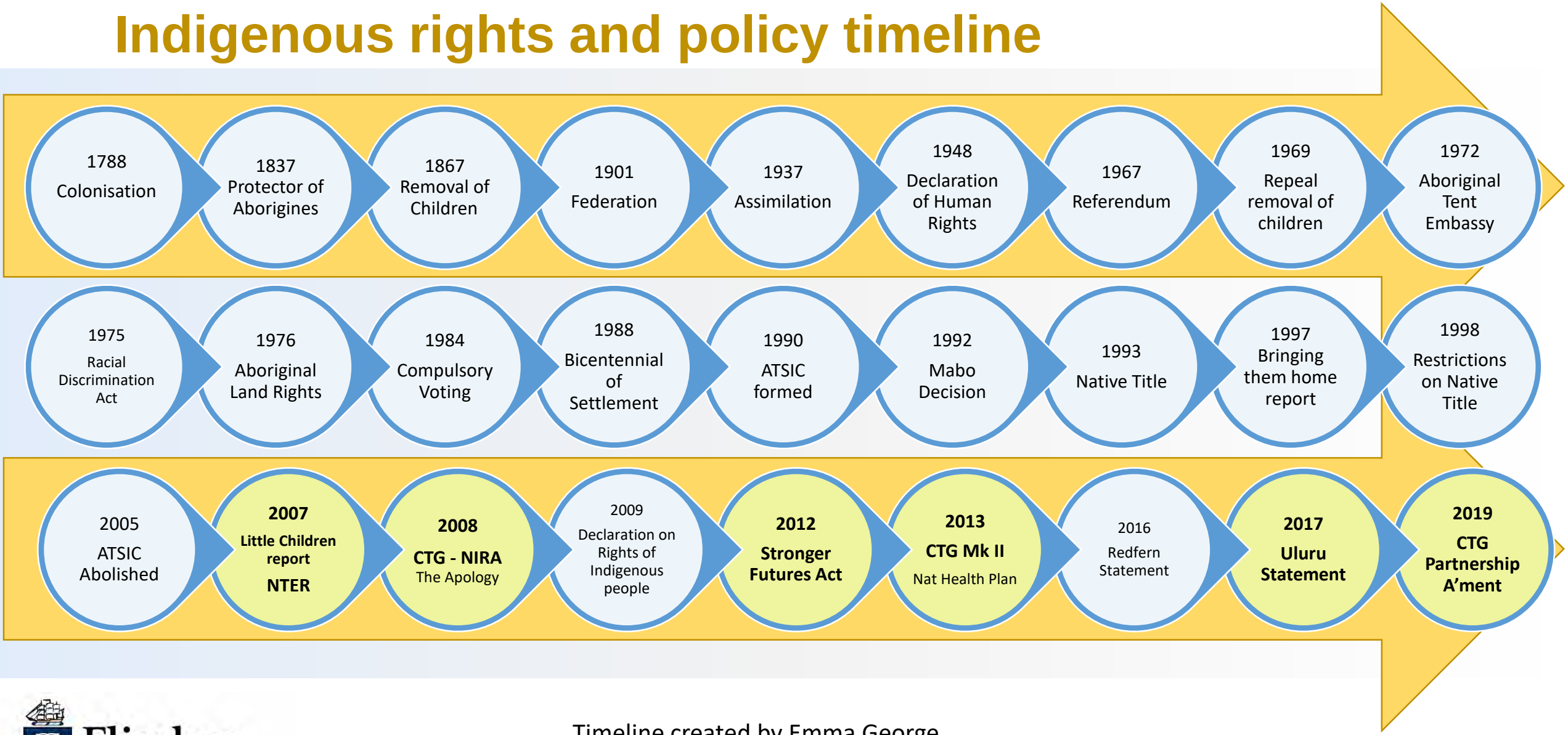
Indigenous rights and policy timeline



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Timeline created by Emma George

Northern Territory Emergency Response

"We have a long, proud history of advocacy, and any gain First Nations people had, is as a direct result of our advocacy. That's the leitmotif running through the struggle, with a capital S … And each generation have taken up that cudgel and taken it just that little bit further."

Aboriginal Interviewee

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NTER Policy Agenda Setting - Methods

- 3 perspectives: Little Children Are Sacred report (NT Govt)
  Northern Territory Emergency Response (Federal govt)
  Alternative Plan (Aboriginal organisations)

- Document framing analysis (72 media releases, speeches, documents, 15 June – 17 August 2007)

- 21 interviews (NT Govt / LCAS, NTER/Federal government, Alternative Plan actors, other experts and stakeholders), 8 Aboriginal and Torres Strait Islander.

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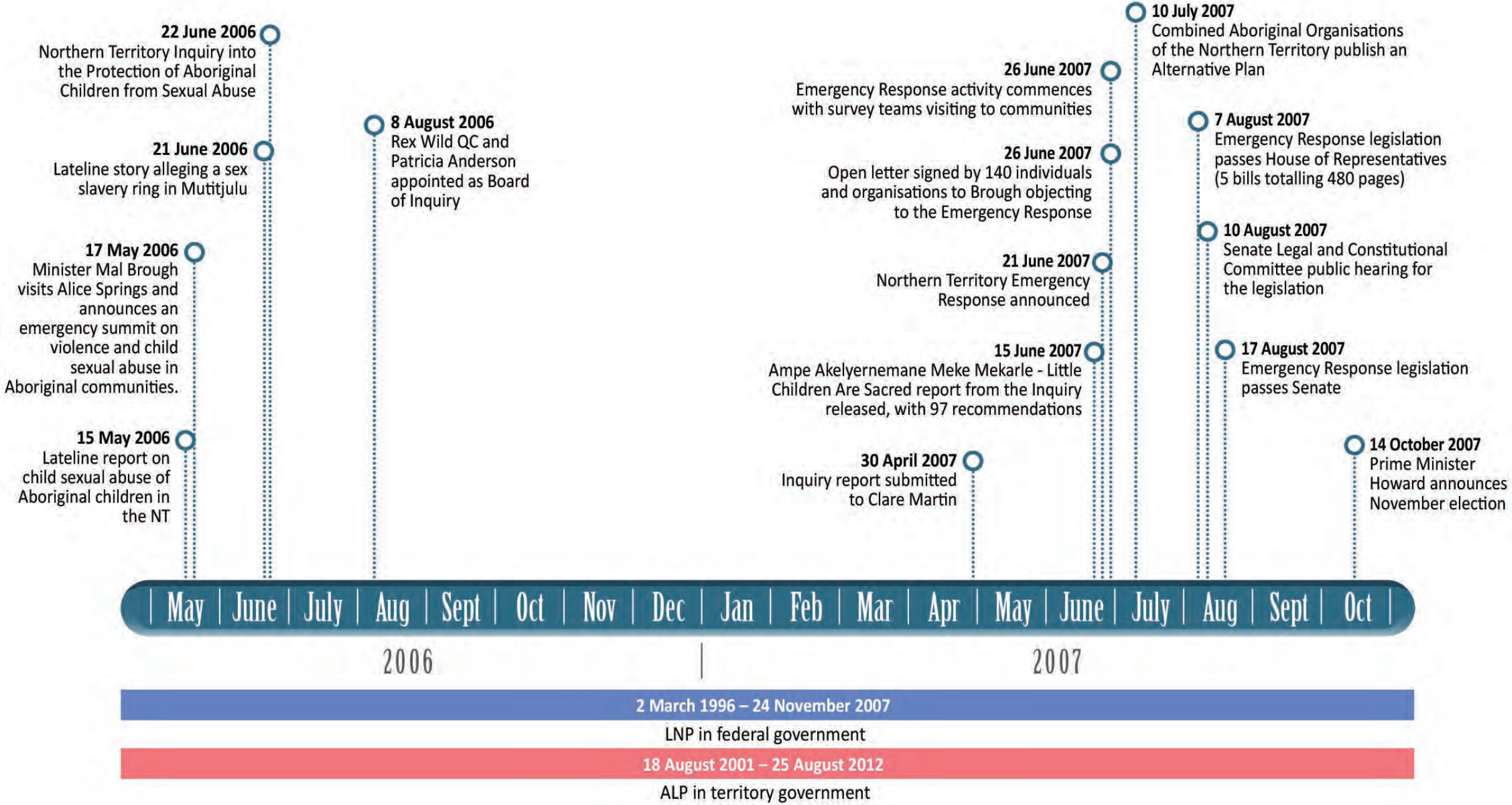
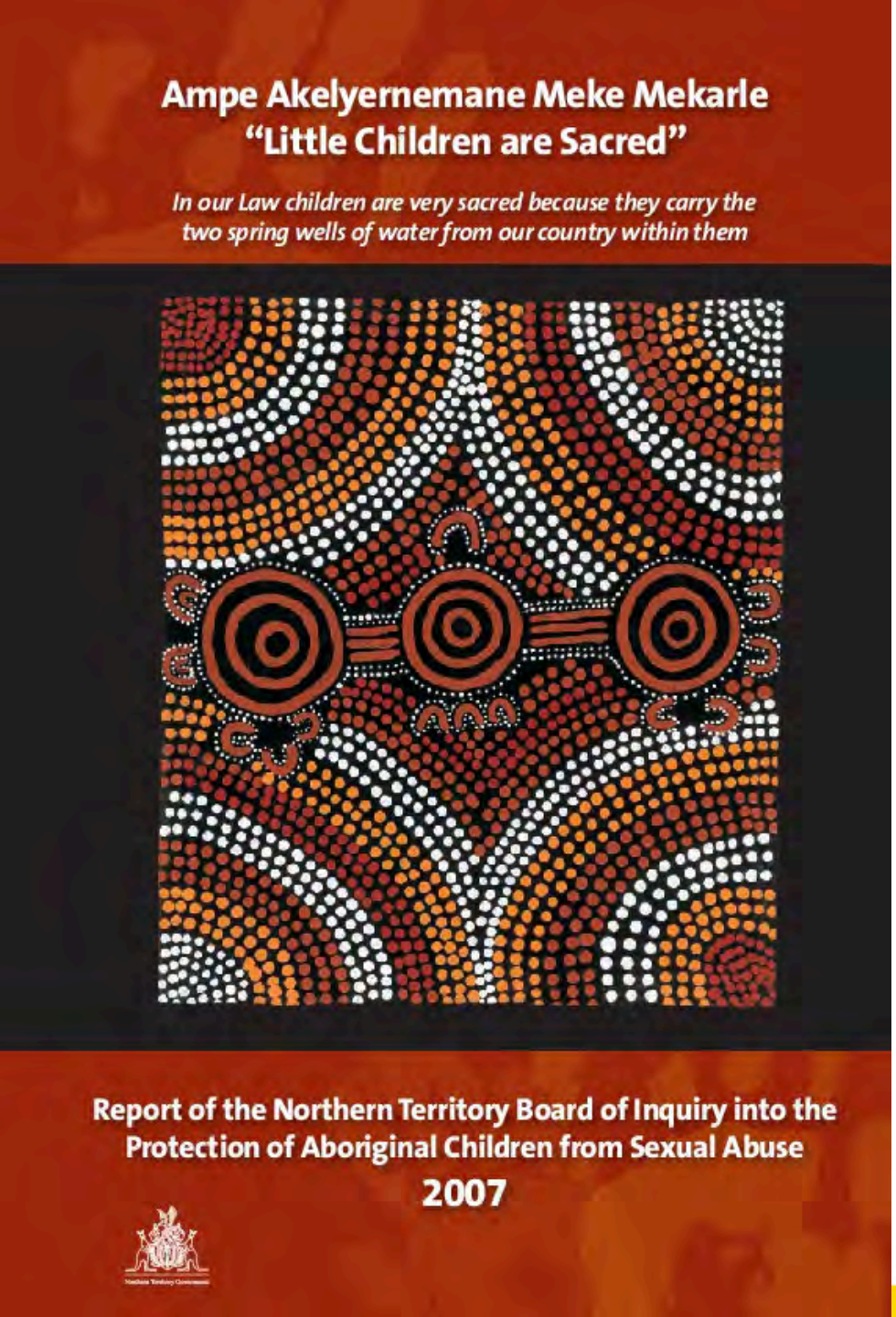

22 June 2006
Northern Territory Inquiry into the Protection of Aboriginal Children from Sexual Abuse
21 June 2006
Lateline story alleging a sex slavery ring in Mutitjulu
17 May 2006
Minister Mal Brough visits Alice Springs and announces an emergency summit on violence and child sexual abuse in Aboriginal communities.
15 May 2006
Lateline report on child sexual abuse of Aboriginal children in the NT
8 August 2006
Rex Wild QC and Patricia Anderson appointed as Board of Inquiry
10 July 2007
Combined Aboriginal Organisations of the Northern Territory publish an Alternative Plan
26 June 2007
Emergency Response activity commences with survey teams visiting to communities
26 June 2007
Open letter signed by 140 individuals and organisations to Brough objecting to the Emergency Response
21 June 2007
Northern Territory Emergency Response announced
15 June 2007
Ampe Akelyernemane Meke Mekarle - Little Children Are Sacred report from the Inquiry released, with 97 recommendations
30 April 2007
Inquiry report submitted to Clare Martin
7 August 2007
Emergency Response legislation passes House of Representatives (5 bills totalling 480 pages)
10 August 2007
Senate Legal and Constitutional Committee public hearing for the legislation
17 August 2007
Emergency Response legislation passes Senate
14 October 2007
Prime Minister Howard announces November election
May June July Aug Sept Oct Nov Dec Jan Feb Mar Apr May June July Aug Sept Oct
2006
2007
2 March 1996 – 24 November 2007
LNP in federal government
18 August 2001 – 25 August 2012
ALP in territory government



Little Children Are Sacred

- Widely regarded to be very consultative, high quality, taking on a complex topic
- Maybe too complex, too many priorities
- NT Labor government criticised for sitting on the report for 6 weeks:

"In that space, that allowed others who had other agendas, it gave them the opportunity to do, and say, and act as they wished, and to use the report in a way that they wished. And that led to the intervention."

Others felt "That's ridiculous. Tell me how many other government reports get sat on for months"

Dysfunction was in the white government

- NT govt "blindsided" – "Howard told her it was just purely political, it was just an opportunity. It was nothing deeper than that."
- Brough (Aboriginal Affairs) "ambitious", "army man" supported by Howard
- Intervention aimed to get government re-elected in November 2007 election
- Labor supported Intervention, didn't want to be seen to oppose + believed in some of the philosophy:

"they had a view as well that if you can control people and I suppose manipulate their environment, then they will respond to that."

Two other motives

1. Welfare reform experiment:

"It was definitely the beginning of them wanting to roll out income management over a wide section of not just Aboriginal people but broader Australia - but definitely for Aboriginal people"

2. Pursue existing agendas to "fix" Aboriginal affairs in NT:

"There's a whole lot of things that the Federal government hated about Aboriginal policy and affairs in the Northern Territory and they just wanted to get it all in one fell swoop. And so they threw everything that they didn't like or were offended by, like closed communities or having to get permits and stuff like that."

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Lack of consultation, partnership

- Massively insular "You couldn't get to speak to anybody. Not even the bureaucracy. Simply nobody was interested."
- Brough as "man of action". Assimilationist, war-like: "you don't tell the enemy you're going to invade"
- Aboriginal people, organisations as part of the problem, not the solution:

  "We tried and we walked the halls of Parliament House and the media, you know the press gallery and so on. And it was almost like, oh no, you lot are irrelevant because you're part of the problem, you covered this up, that you're complicit in these things … you're part of the problem."
- Ignorance of what life is like in remote communities

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Kevin Rudd offers to team up with Tony Abbott on Indigenous recognition in constitution

By political editor Andrew Probyn

Posted Fri at 3:46pm

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Only thing to change

- Change from mandatory child sexual abuse checks to child health checks
- Attributed to Combined Aboriginal Organisations, AIDA, AMSANT, government health bureaucrats, Tony Abbott
  - came from multiple, powerful quarters

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Dilemmas faced by Aboriginal organisations

- Whether to refuse to get involved, or try to steer it to better outcomes:

"[Organisation] had a real struggle whether we were going to be involved at all because we were so against that whole process, the way it was done and the reasoning and the politics. So we struggled with that … We have to be involved and we have to help shape something good out of this, and it's for them, not for us and not for our egos or our ethics. We've got to just try and do the right thing by those countrymen up there."

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Lessons for future policy agenda setting

- Structure for self-determination:

"Aboriginal and Torres Strait Islander people have to be properly resourced to participate in those processes so they can go to these meetings with prepared policy arguments to put forward. And that's where government's never funded the, what I call the processes of self-determination."

- Aboriginal and Torres Strait Islander representation in parliament:

"It comes from a lack of Indigenous people in either federal parties, in the federal party's caucuses essentially. There is no way, there is no way that would happen now with Patrick Dodson and Linda Burney there."

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Lessons for future policy agenda setting

- Collective action:

"We've been very, very effective in our advocacy role, our responding to government policy. We've undertaken numerous submissions around Senate and House of Rep enquiries. So establishing APONT [Aboriginal Peak Organisations NT] became a very effective strategy to deal with Government."

"I think the other thing for us as Aboriginal people is we've actually got a pretty good understanding of how government and politics works … we know how to mobilise, we know how to strategise … it's just that we don't have the political and the legal leverage or the power."

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Close the Gap

Associate Professor Tamara Mackean and
Dr Matt Fisher
Flinders University

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Closing the Gap 2008 – 2018

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Research on the implementation of Closing the Gap policy 2008-18

- CTG policy implementation nationally and in two States
- Policy mapping, monitoring and analysis
- 44 interviews with key informants nationally & in two States
- Embedded case studies in two regions: Shepparton and Sth Adelaide
- PhD project: Ms Emma George - Implementation of CTG policies on early childhood in two regions

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Theory used in the research

- Mason Durie – **Research at the interface between knowledge systems**: principles of *Mutual respect, Shared benefits, Human dignity, Discovery*
- **Decolonising** research methodologies
- **Cultural safety*** – ***Reflexivity, Dialogue, Reducing power differences, Decolonisation*** *and* ***Regardful care*** in public policy
- **Policy theory on implementation**: *Ideas, actors and structures; top-down and bottom up views of implementation; Methods of policy governance*

*** Mackean, Fisher et al. A framework to assess cultural safety in Australian public policy. *Health Promotion International***

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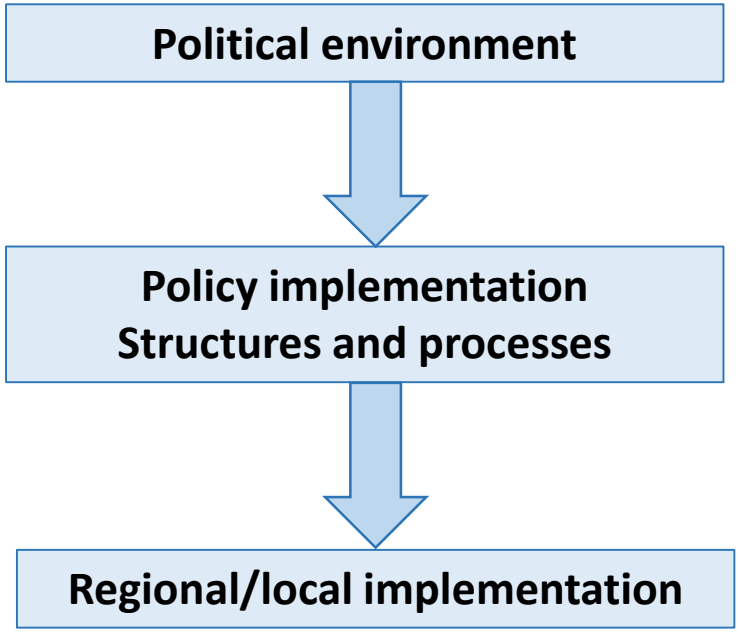
Our presentation today…

- Strengths and weaknesses in current CTG implementation in…
  - The political environment surrounding and shaping CTG policy
  - National and state government implementation structures & processes
  - Local and regional structures and processes
- Framework for improved policy implementation
- Cultural safety in a changing political environment



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National political environment 1 – weaknesses

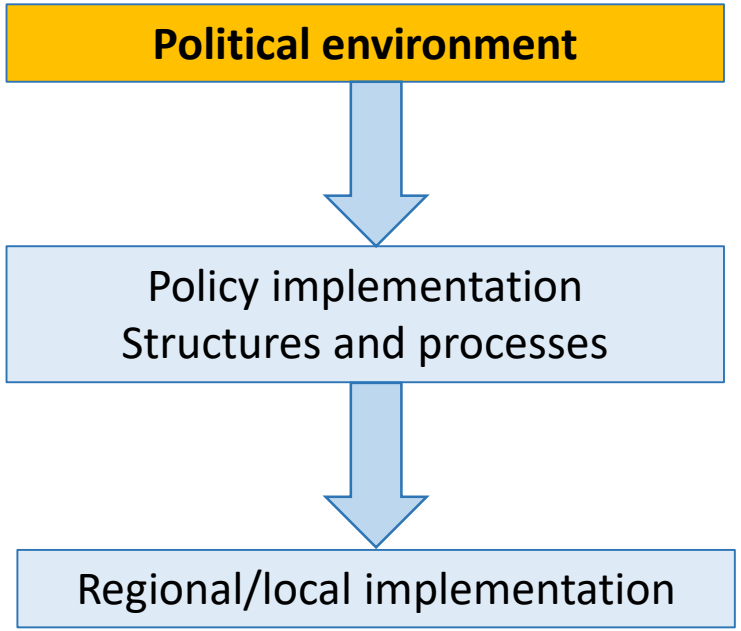
- Aboriginal and Torres Strait Islander people as a subject of contested political debate
- Constant **policy 'churn'** and short-term thinking:

  "…. Indigenous policy in Australia suffers from a constant resetting and the most important thing that could happen would be some long term stability"

- **Policy incoherence** – CTG policy aims undermined by policy in other areas

  "…we've had the continuation of the NT Intervention and Stronger Futures which in many cases directly conflicts with what they're trying to do with Close the Gap"

- Lack of a **long-term, systemic, partnership** approach to policy



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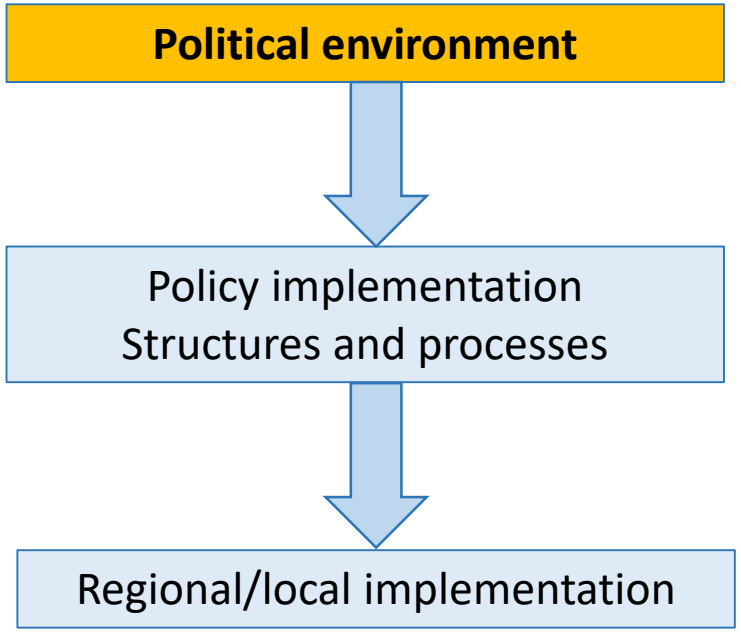
National political environment 2 – strengths

- Aboriginal and Torres Strait Islander political leadership
- Values and ideas: shared sovereignty, Voice, Makarrata, truth telling, self-determination
- A long-term perspective; a systemic approach
- New partnership approach to Closing the Gap



"…we should be backing the voice to parliament because it … will require a process that the parliament needs to undertake which is not dependent on 3-year government terms or the ability of governments to change legislation at their whim"

- *But…*

"I think there has been some positives and having [the targets] there is good but I think it's a failure of implementation; of people to actually implement things that's the problem"

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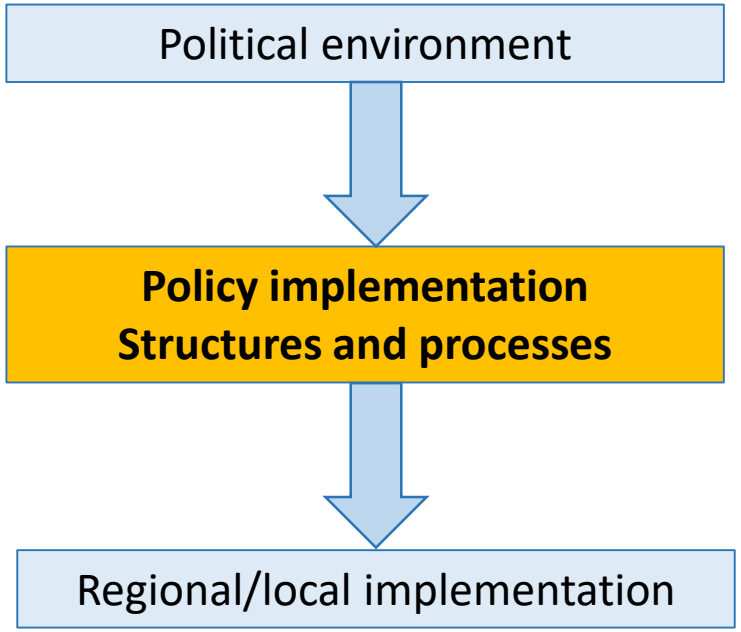
National policy implementation environment 1 - weakness

- National mainstream agencies and services in health, education, social services and employment are not doing enough
  - This is where majority of social policy funding is spent
  - Increased accountability
  - Federal – State/Territory collaboration
  - Aboriginal and Torres Strait Islander health sector as a model of good practice

"…targeted programs account for about 7% of the spend and the 93% now need to do the heavy lifting"

"…there's still not that strong focus on holding commonwealth and state government departments accountable for working towards delivery on the Close the Gap targets"



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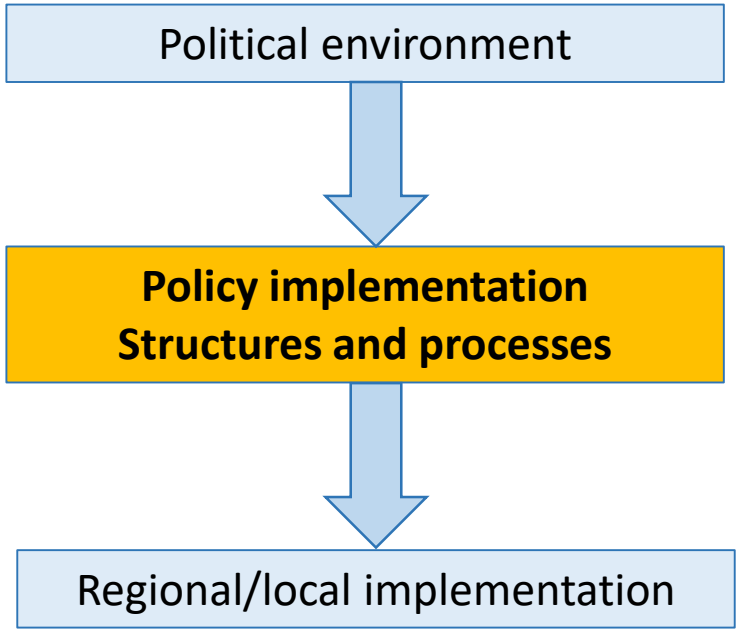
National policy implementation environment 2 - strengths

- National Aboriginal and Torres Strait Islander Health sector - good practices:
  - Aboriginal and Torres Strait Islander leadership
  - Culture at the centre, recognition of racism, social determinants of Indigenous health
  - Partnership approach to policy*
  - Resourced representative organisations and ACCHOs
  - Collaborative approach with State/Territory agencies
  - Policy consistency – a long-term approach



Fisher, et al. (2018) How the Social Determinants of Indigenous Health became policy reality for Australia's National Aboriginal and Torres Strait Islander Health Plan, *Journal of Social Policy

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National policy implementation environment 3 – targets & targeted funding

- Role of 'Closing the Gap' targets

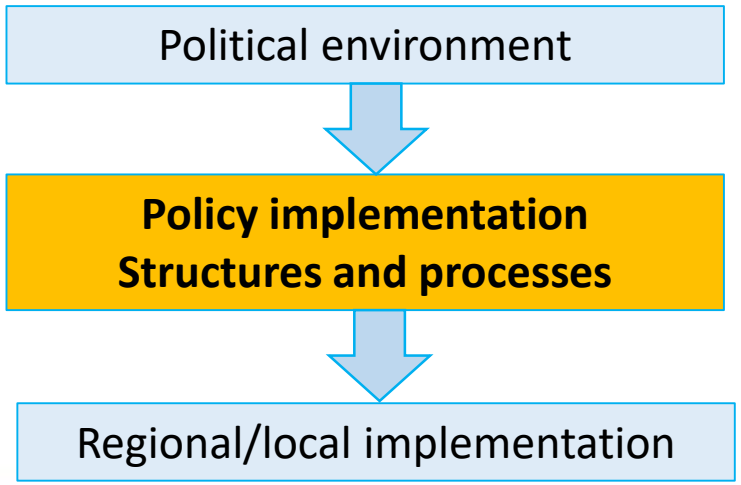
"…having the targets through COAG has been very useful. … It's brought Indigenous policy much more centrally to the national policy agenda. Every year the PM … holds the government to account"

"[…] while ever we've got 'closing the gap' … it necessarily frames us in the deficit. …The vision for me is that we are strong First Nations people and able to prosecute the very best for our kids and our grandkids"

"Until … there is a voice … there is self-determination … there is participation and people can be agents of change in their own communities … we're not going to see the sort of change that's indicated by the targets"

Targeted funding:

- Proliferation of programs & services
- Marketised approaches
  - Fragmented service delivery environment
  - One-size-fits all approaches; deficit focus
  - Loss of services; workforce problems
  - Complex, onerous reporting demands
  - Duplication of services



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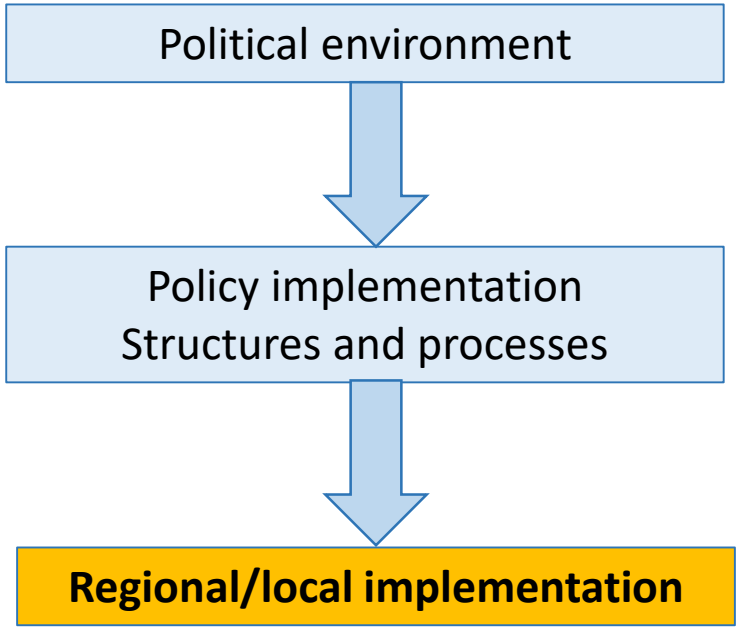
Regional/local implementation 1 – strengths

- Regional/local decision making structures
- Key role of ACCHOs & other community-led organisations
  - Key 'venue' for self-determination
  - Valuing local cultural context
  - Flexible response to local needs
  - Community leadership
  - Strength-based approach
  - Local/regional partnerships
  - A representative voice
  - Capacity building



"Now our position on that is we would like a focus around building local and regional decision making that will hold both Indigenous engagement as a key principle [and] local accountability"

"I mean fundamentally this is self-determination … but a regional approach can't just be … imposing a government decision. Lifting the capacity of a region and of community to step in and to take control, that should be given by Aboriginal expertise"

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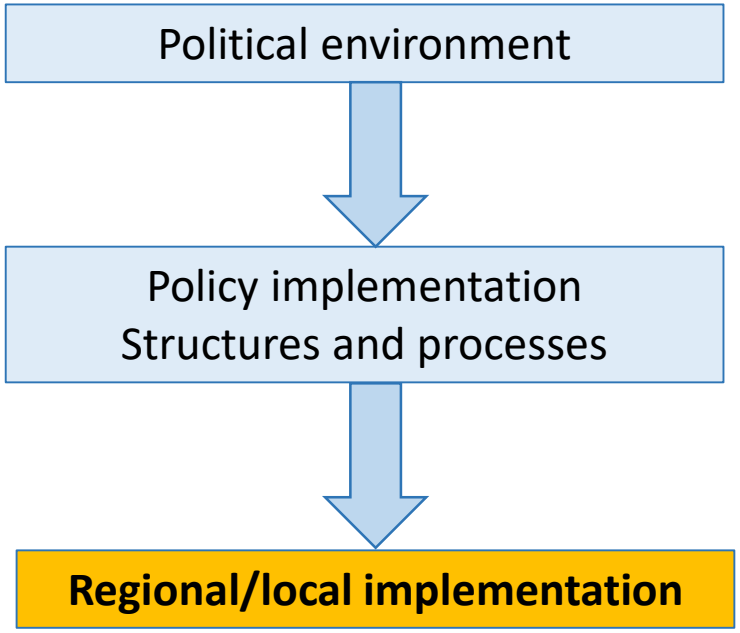
Regional/local implementation 2 – Weaknesses

- Reform in funding & regulate
- Top-down structures resistant to change
- ACCHO funding complex and inflexible
- Lack of funding support for community-led, strength-based strategies
- Demands made on community organisations and individuals by government agencies



"I guess in summary that's really about just recognising that the structural drivers are very embedded and very powerful. Change will always be resisted"

"…particularly in a self-determination agenda … requests and demands of Aboriginal organisations are only increasing … I don't think that that's something that we have the answer to at the moment"

"I worry that if some organisations that aren't ready to provide good governance are given the responsibility to provide the platform for a place-based approach, they're really being set up to fail."

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National political and policy environment

THE HON KEN WYATT AM MP

Minister for Indigenous Australians

PARTNERSHIP AGREEMENT ON CLOSING THE GAP 2019–2029

the Lowitja Institute

NACCHO www.naccho.org.au

Indigenous Evaluation Strategy

Productivity Commission Issues Paper

June 2019

NHLF National Health Leadership Forum

NATIONAL CONGRESS OF AUSTRALIA'S FIRST PEOPLES

CLOSETHEGAP

NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PLAN 2013–2023

RECONCILIATION AUSTRALIA

Joint Select Committee on Constitutional Recognition relating to Aboriginal and Torres Strait Islander Peoples

The Redfern Statement 2016

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Cultural safety in public policy

- Development & publishing of a framework to assess cultural safety in public policy
  - ***Reflexivity, Dialogue, Reducing power differences, Decolonisation, Regardful care***
- Need for **structures and processes** to realise these attributes in policy
- Policy will be culturally safe when all elements are addressed


Health Promotion International, 2019, 1–12
doi: 10.1093/heapro/daz011
Article
OXFORD

A framework to assess cultural safety in Australian public policy

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Reflexivity: recognition – reflection & learning – accountability

- **Reflexivity** in policy requires **acknowledgement** and **accountability** for the impacts of whiteness and privilege and **recognition** of the cultures, capabilities and knowledge of Aboriginal and Torres Strait Islander peoples

Current national picture:

- Lack of structures for governments to be **accountable** for impacts of institutional and individual biases on Aboriginal and Torres Strait Islander people's lives
- Lack of structures for government agencies to **recognise** and **value** a sense of control, strong cultures, Indigenous knowledges, and strength-based approaches as essential elements of effective policy

Key national structures for change:

Political environment **Agenda setting**	• ***National truth telling and Makarrata Commission*** • ***Constitutional recognition***
Implementation structures & processes	• COAG Partnership Agreement on Closing the Gap • Prod. Commission Indigenous Evaluation Strategy • Revised CTG targets, PM's annual report

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Dialogue: Partnership – Relationship building – Listening

- Dialogue in policy requires enduring policy **partnerships** across the policy cycle between governments and well-resourced Aboriginal and Torres Strait Islander organisations; and broad, timely consultation with Aboriginal and Torres Strait Islander communities.

Current national picture:

- Limited structures to support a **partnership** approach to policy making, across the policy cycle and in all key policy areas; Aboriginal and Torres Strait Islander health sector shows good practice

Key policy structures for change:

Political environment **Agenda setting**	• ***Voice to Parliament*** • **National Congress; AHRC; CTG Campaign**
Implementation structures & processes	• COAG Partnership Agreement on Closing the Gap • Partnership approach in Health sector as a model of good practice • *National agencies: Education, Employment, Social Services* • Sector-based Aboriginal and Torres Strait Islander peak bodies

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Reducing power differences - Support for leadership – Empowerment

- **Leadership** and **empowerment** are key ways to address power imbalances in: political leadership, influence over public policy, ability to exercise control at a local/regional level

Current national picture:

- Lack of political support for Uluru Statement from the Heart
- Lack of funding and regulatory structures to support community-led regional/local governance structures and empowerment processes

Key national structures for change:

Political environment **Agenda setting**	• ***Voice to Parliament*** • **Support for Aboriginal &Torres Strait Islander leaders and funding national representative organisations**
Implementation structures & processes	• COAG Partnership Agreement on Closing the Gap • Government agencies & sector-based peak bodies • Aboriginal Community-Controlled Health Organisations • *New policy structures to support regional governance and flexible, strength-based community empowerment strategies*

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Decolonisation: Self-determination – Cultural identity – Address racism

- Decolonisation in policy requires support for **self-determination** and rights, valuing of Aboriginal and Torres Strait Islander **cultures**, and processes to address **racism**

Current national picture:

- Lack of structures and values to prioritise self-determination and reduce impacts of incarceration, removal of children and compulsory income management
- Lack of structures to recognise Indigenous Rights

Key national structures for change:

Political environment **Agenda setting**	• ***Constitutional recognition*** • ***National truth telling and Makarrata Commission*** • **Reconciliation Australia; Aust Human Rights Commission**
Implementation & evaluation	• *COAG – national agreements to prioritise self-determination and reduce incarceration, child removal, income management* • COAG Partnership Agreement on Closing the Gap • State/Territory governments

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Regardful care: Indigenous knowledges – Culturally safe healthcare – Action on SDIH

- Regardful care requires services that engage with cultural and community context, value **Indigenous knowledges**, provide **culturally safe healthcare**, support **strength-based approaches** and address SDIH

Current national picture:

- AMSs & other services provide culturally safe PHC; ACCHOs provide comprehensive PHC services
- Fragmented, competitive funding environment – can favour non-Indigenous NGOs or private providers
- Limited cultural safety in mainstream programs and services: health care, education, employment
- Lack of structures to support strong local governance & flexible, community-led, strength-based services

Key structures for change:

Political environment **Agenda setting**	• ***Makarrata Commission***
Implementation & evaluation	• *National agreements to prioritise ACCHOs; consistent funding, simplified regulation* • COAG Partnership Agreement on Closing the Gap • 'Mainstream' policy agencies: health, education, employment, social services • Prod. Commission Indigenous Evaluation Strategy

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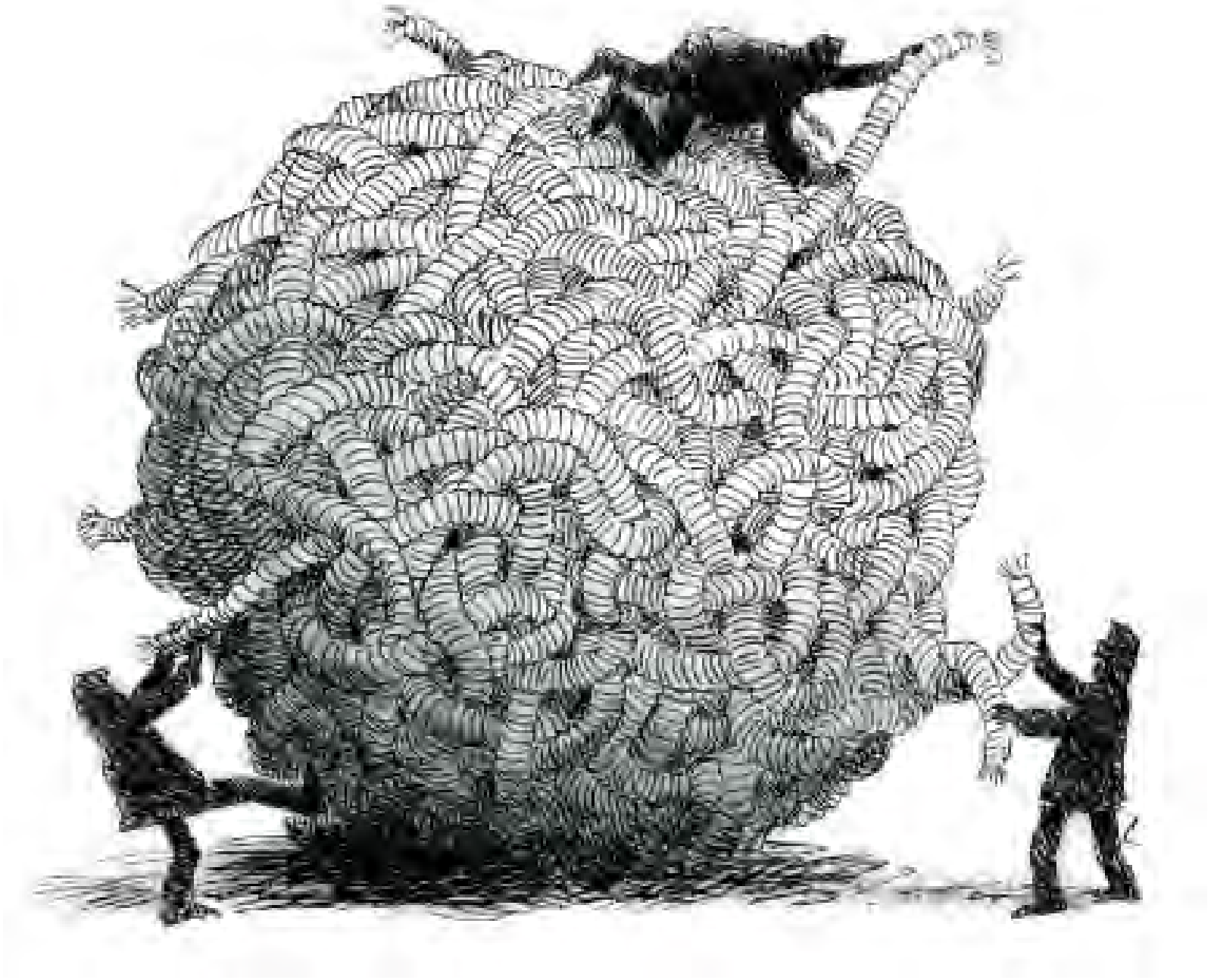
Conclusions

- Policy agencies and implementation are moving ahead of the political debate in achieving some elements of culturally safe policy
- Some structural elements of policy implementation needed for culturally safe policy are still missing or under-realised
- New structures such as the *Partnership Agreement on Closing the Gap* between the Coalition of Aboriginal and Torres Strait Islander Peak Bodies and COAG build on previous achievements and provide opportunity for positive change
- *The Uluru Statement from the Heart* proposes key structures needed to achieve and extend cultural safety in the Australian political environment

CRE HEALTH EQUITY




NO BYO
Coca-Cola

INDIGENOUS KNOWLEDGE AS AN 'UNRAVELLER'

- Draw on core Indigenous Australian epistemologies - ways of knowing, being and doing - that offer concepts and approaches applied and honed over millennia.
- Consider including such approaches as:
- *Dadirri* (Deep Listening). An *inner, deep listening and quiet, still awareness … something like what you call contemplation*

INDIGENOUS KNOWLEDGE AS AN 'UNRAVELLER'

'Doublies' (Seeing 'two-ways' - considering both sides simultaneously)

The most profound philosophy I learnt from our people is this idea of seeing the world differently – in two ways. What about the hidden story? You need to ask:

Have you looked around the mountain? What's on the other side? What's beneath the story? What's between the lines?

What else can you gather?

INDIGENOUS KNOWLEDGE AS AN 'UNRAVELLER'

'Doublies' (Seeing 'two-ways' - considering both sides simultaneously)

- *It has obvious parallels to western modes of critical inquiry, but adds the element of seeing utility in holding disparate, even contradictory, views at the same time*

INDIGENOUS KNOWLEDGE AS AN 'UNRAVELLER'

***Kanyini*(the principle of interconnectedness), activated through stewardship and responsibility:**

> *Stewardship implies a conscious, and conscientious, embrace of responsibility for pro-actively fostering national health and well-being*

SESSION 4
What Have We Learnt About Actions For Health Equity?

Session Chair:

Dr Tessa Boyd-Caine
Chief Executive Officer
Health Justice Australia

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NHMRC Centre for Research Excellence
in the Social Determinants of Health Equity

What have we learnt about actions for health equity?

Professor Sharon Friel, School of Regulation and Global Governance and CRE co-Director
@SharonFrielOz

#CREHealthEquity

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1. **Data, knowledge, evidence**
2. **Structure – agency - Power**
3. **Relationships and commitment**

Data, Evidence, Knowledge

THE 'WHY'

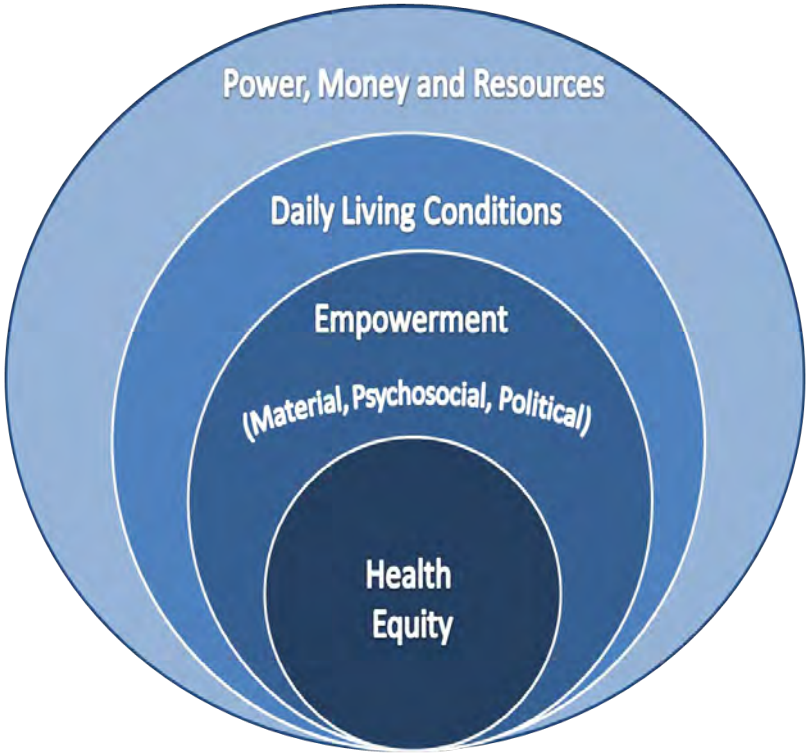
Describing the problem

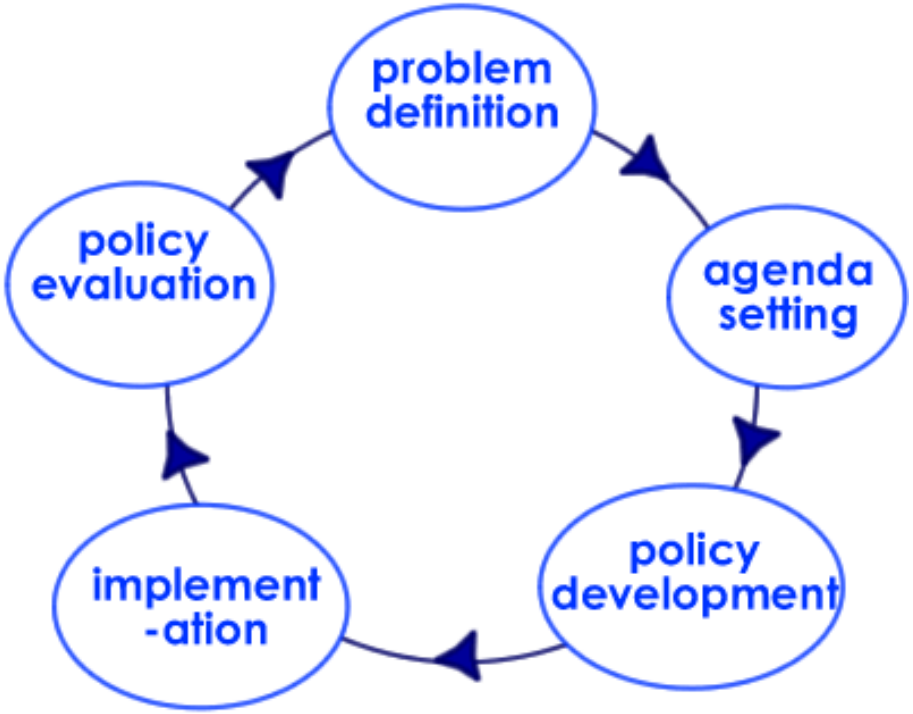
THE 'HOW'

Actors, institutions, structures, processes and contexts

THE 'WHAT'

Policy prescriptions





Trade; Labour Market; Employment; Infrastructure; Welfare; Health

What we measure changes how we act…

- Constantly losing sight of the structural drivers of health inequities
- Focusing on the downstream indicators
- Through a Western-lens

Structure - Agency - Power throughout the policy process

Webs of actors

- State / non state
- Public / Private
- Health / Other sectors

Forms of power

- Structural
- Instrumental
- Discursive

Spaces and levels

- Global/national/local
- Closed/invited/claimed

Some of the consequences

- Dominant paradigm
- A focus on the individual
- Deregulation
- Path dependency
- Do nothing
- Rolling back
- Entrenched racist views and practices
- Winners and losers

How to

E vidence
F raming strategically
F orum shop
E xternal and internal policy processes
C oalition building
T argeted messaging

policy action on SDH/HE

In pursuit of policy coherence

Major structural transformation: Industrial transition

- Systems response
- Multilevel multisectoral governance
- Policy silences

From parchment to practice

Mixed policy design

National agreements for universal access

Regional governance structures

Public budgeting models

Relationships and commitment

Webs of influence

Public Health Association AUSTRALIA

Health for All Now!
People's Health Movement

I

The Lowitja Institute

Rising political consciousness

Collective action

Organised strategy

CRE CPRG

AFTINET
Australian Fair Trade & Investment Network Ltd

Health Justice Australia

Reasons to be hopeful…

- Good evidence and analysis that understands the systems
- A spectrum of public interest policy and regulatory designs and interventions
- Organised networks of influence
- Persuasive strategy and tactics

Pushing at doors with a shared collective vision

CRE HEALTH EQUITY

Questions

SESSION 5
Advocacy Ideas Panel

Session Chair:

Adjunct Professor Peter Sainsbury
Public Health Specialist
Past President PHAA and Climate Health Alliance

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NHMRC Centre for Research Excellence
in the Social Determinants of Health Equity

Advocacy Ideas Panel

Civil Society: A Force for Health and Equitable Societies

Panellists:

- **Dr Belinda Townsend**, Australian National University
- **Professor Fran Baum**, Flinders University
- **Mr Ross Womersley**, SACOSS
- **Dr Tessa Boyd-Caine**, Social Determinants of Health Alliance

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