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
WELCOME
Introduction and Overview

Session Chair:

Professor Jonathan Craig
Vice President and Executive Dean
Flinders University
Welcome to Country

Uncle Lewis Yerloburka O'Brien, AO
Opening Address

The Honourable Dr Richard Harvey MP
Member for Newland
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 #CREHealthEquity
CRE Health Equity 2015-20

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

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

- Health Equity
- (Material, Psychosocial, Political)
- Empowerment
- Improved Daily Living Conditions
- Fair Distribution of Power, Money and Resources
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
“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”.
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”
“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”.

Professor Mary T Bassett
Harvard T.H. Chan School of Public Health
### POLICY PROCESSES

<table>
<thead>
<tr>
<th>WORK PACKAGE 1</th>
<th>WORK PACKAGE 2</th>
<th>WORK PACKAGE 3</th>
<th>WORK PACKAGE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making health equity a policy concern</td>
<td>Formulating policy: understanding complex systems &amp; policy coherence</td>
<td>Effective implementation for health equity</td>
<td>Health equity impacts of public policy &amp; action</td>
</tr>
</tbody>
</table>

**CRESDHE RESEARCH PROGRAM**

<table>
<thead>
<tr>
<th><strong>Problem identification &amp; Agenda Setting</strong></th>
<th><strong>Policy solutions / formulation</strong></th>
<th><strong>Implementation</strong></th>
<th><strong>Evaluation of impact on health equity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand the ideas, actors &amp; institutions which shape policy to determine how to make health equity a policy concern in the future</td>
<td>Improved conceptual &amp; empirical understanding of how sectoral policies interact to affect health equity</td>
<td>How can the implementation of SDH action be enhanced and maintained?</td>
<td>What are the health equity impacts of policies and practice in SDH?</td>
</tr>
</tbody>
</table>

**Case studies**

- Medicare
- Paid Parental Leave
- Trans Pacific Partnership agreement
- Northern Territory Intervention
- Holden closure in Playford South Australia
- National Broad Band
- NSW Land use legislation
- Primary Health Care
- Closing The Gap
- National Broad Band
- NSW Land use legislation
- Primary Health Care
- Closing The Gap

### CROSS CUTTING THEORIES AND METHODS:

Bourdieu, Harvey & Sen; Policy theory; Complex systems; Theory driven program logic; Integrated knowledge translation across disciplines and sectors, Interface of different Knowledge Systems
Evaluation of the impact of health-sector policy and programs on health equity; Applying a health equity lens to non-health sector policy and programs.

Understanding how SDH and health equity gets onto (or doesn’t) the political and social agenda.

Understanding the barriers and opportunities: systems, processes and actors.

What does SDH policy and action look like?

NHMRC Centre of Research Excellence on Social Determinants of Health Equity (C RESDHE): 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

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

**RESEARCH PROGRAM**
Work Packages 1-4
Integrated knowledge translation and engagement

**LEVELS**
- Local
- State/Territory
- National
- International

**EVIDENCE USERS**
- Policy/decision makers;
- Service delivery practitioners;
- Researchers;
- Private sector;
- Media;
- Investigators from other disciplines and countries

**THEMATIC ISSUES**
- Macroeconomic & Infrastructure;
- Land use and urban environments;
- Health system;
- Racism

**TRANSLATION: ENGAGEMENT MECHANISMS & DISSEMINATION STRATEGIES**
- Associate Investigators
- Critical Policy Reference Group
- International Translation Group
- Annual Policy Symposium Content round tables
- Journal articles
- Policy Briefs
- Social Media
- Conference presentations

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 Symposia

- 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 health, Aboriginal and Torres Strait Islander organisation engagement
- Multiple meetings with politicians and other policy makers and civil society actors
- Policy briefings
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

http://regnet.anu.edu.au/
Translating our research: Rapid summaries for busy policy actors

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

NBN

Dr Toby Freeman and Dr Matt Fisher
Flinders University
@drtobyfreeman
#CREHealthEquity
The National Broadband Network

How equity got lost in implementation
Context

• Previously public telecommunications provider, since privatised

• Universal service obligation

• Lack of investment in next gen infrastructure → government intervention
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
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
So Just How Borked Is The NBN?
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)
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
Broadband costs rank among worst in world

Matt Coughlan

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)
NBN policy 2008-2019 – inequities in quality

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

Urban Planning in Greater Sydney: Lessons for other jurisdictions

Dr Patrick Harris
University of Sydney
@PHarrismusings
#CREHealthEquity
Urban Planning meets infrastructure in Greater Sydney
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 (e.g., 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.
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.”
NSW Planning system activity and health’s incremental inclusion

- NSW Planning Review
- ‘Health’ 2 of 11 draft objectives
- ‘Health’ 1 of 4 Directions
- Metro Strategy
- Bills officially fail
- Greater Sydney Commission established
- Legislative amendments debated
- Draft GSC plans
- Final GSC plans (+ Future Transport, Infrastructure plans)
- Implementation: Western Sydney City Deal
- Health + equity
- Design + healthy buildings objectives
- ??
Western Sydney City Deal

OUR GREATER SYDNEY 2056
Western City District Plan
– connecting communities

Smart Cities Plan
IMPLEMENTATION
Western Sydney City Deal
December 2018

[Logos and text of various organizations]
Plan-making and The Greater Sydney Commission: The equity (and infrastructure) opportunity
## COMMITMENTS FRAMEWORK
for the City Deal

<table>
<thead>
<tr>
<th>Measuring performance</th>
<th>Liveability and Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Liveability and Sustainability</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Performance indicator</td>
</tr>
<tr>
<td></td>
<td>- Access to green space area</td>
</tr>
</tbody>
</table>

### Amenity and liveability across the Western Parkland City

### L1 - Western Parkland City Liveability Program

### Improve community health

### L5 - Western Sydney Health Alliance

<table>
<thead>
<tr>
<th>Commitment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>
‘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?’
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

“$5.3 billion is a significant investment, so how do you maximize the benefits of that more broadly in the wider precinct?”
<table>
<thead>
<tr>
<th>Harvey (1989) on new entrepreneurialism</th>
<th>The discourse in the Deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competition for labour and capital means creating or exploiting opportunities to gain competitive advantage for the production of goods and services</td>
<td>Increased business investment to ‘deliver transformative change to the region’.</td>
</tr>
<tr>
<td>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</td>
<td>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’.</td>
</tr>
<tr>
<td>The positive potential for urban entrepreneurialism to create positive change through ‘agglomeration economies and efficient organisation’</td>
<td>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’</td>
</tr>
<tr>
<td>Hardly any large scale development occurs without local government offering a substantial package of inducements</td>
<td>The overall discourse in the plan leans toward government investment to open up the region for investment and employment.</td>
</tr>
</tbody>
</table>
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’.

Flinders UNIVERSITY
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.”
| 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. |
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.
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
SESSION 2
Globalisation: Trade and Work

Session Chair:

Ross Womersley
Chief Executive Officer
SA Council of Social Services
Trade and Health: Lessons in agenda-setting and evaluation

Dr Ashley Schram
Australian National University
@ashleylschram
#CREHealthEquity
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

@ashleylschram
ashley.schram@anu.edu.au
Outline

• Why trade policy?

• What did we learn?

• Ways forward?
Why trade policy?

corporate profits and exploiting the planet \rightarrow \text{raising standards}

race to the bottom \rightarrow \text{sustainable equitable global development}

enforcing medicines monopolies \rightarrow \text{sharing best available care}

conscious citizens \rightarrow \text{conspicuous consumers}

conscious citizens \rightarrow \text{conspicuous consumers}

raising standards \rightarrow \text{race to the bottom}
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?
<table>
<thead>
<tr>
<th>Low Levels of Alcohol Abstinence</th>
<th>High Levels of Alcohol Abstinence</th>
<th>Australian exports to 16 countries with a PTA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 50% alcohol abstinence</td>
<td>&gt; 50% alcohol abstinence</td>
<td>Tariff rates and export volumes on alcohol products</td>
</tr>
<tr>
<td>• Chile</td>
<td>• Brunei</td>
<td>~ 7,000 observations (country, product, 1988-2016)</td>
</tr>
<tr>
<td>• China</td>
<td>• Cambodia</td>
<td>Time series analysis and gravity modelling (econometric analysis)</td>
</tr>
<tr>
<td>• Japan</td>
<td>• Indonesia</td>
<td></td>
</tr>
<tr>
<td>• Korea</td>
<td>• Malaysia</td>
<td></td>
</tr>
<tr>
<td>• Laos</td>
<td>• Myanmar</td>
<td></td>
</tr>
<tr>
<td>• New Zealand</td>
<td>• Thailand</td>
<td></td>
</tr>
<tr>
<td>• Philippines</td>
<td>• Vietnam</td>
<td></td>
</tr>
<tr>
<td>• Singapore</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• United States</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Key findings: evidence (alcohol – econometric analysis)

#### Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Share of Imports</th>
<th>Some Imports</th>
<th>Share (given some imports)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTA</strong></td>
<td>0.45**</td>
<td>0.067**</td>
<td>0.34</td>
</tr>
<tr>
<td><strong>GDP</strong></td>
<td>1.25***</td>
<td>0.22***</td>
<td>3.01***</td>
</tr>
<tr>
<td><strong>Exchange Rate</strong></td>
<td>-0.0018</td>
<td>-0.0022</td>
<td>1.730***</td>
</tr>
<tr>
<td><strong>Tariff Rate</strong></td>
<td>-0.042**</td>
<td>-0.011***</td>
<td>-0.017</td>
</tr>
</tbody>
</table>

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

#### Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>High Abstainers</th>
<th>Low Abstainers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTA</strong></td>
<td>1.14**</td>
<td>-0.033</td>
</tr>
<tr>
<td><strong>GDP</strong></td>
<td>1.56**</td>
<td>1.08**</td>
</tr>
<tr>
<td><strong>Exchange Rate</strong></td>
<td>-0.32**</td>
<td>0.24**</td>
</tr>
<tr>
<td><strong>Tariff Rate</strong></td>
<td>-0.19***</td>
<td>-0.016**</td>
</tr>
</tbody>
</table>

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
### Key findings: issues

<table>
<thead>
<tr>
<th>Frame Alignment</th>
<th>Path Dependencies</th>
<th>Treaties/Legislation</th>
<th>Evidence Strength</th>
<th>Limited Exports</th>
<th>Exogenous Events</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="true" alt="Checkmark" /></td>
<td><img src="true" alt="Checkmark" /></td>
<td><img src="true" alt="Checkmark" /></td>
<td><img src="true" alt="Checkmark" /></td>
<td><img src="true" alt="Checkmark" /></td>
<td><img src="true" alt="Checkmark" /></td>
</tr>
<tr>
<td><img src="false" alt="Question" /></td>
<td><img src="false" alt="Question" /></td>
<td><img src="false" alt="Question" /></td>
<td><img src="false" alt="Question" /></td>
<td><img src="false" alt="Question" /></td>
<td><img src="false" alt="Question" /></td>
</tr>
</tbody>
</table>

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

Dr Kathryn Browne-Yung
Flinders University
#CREHealthEquity
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.

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

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

- **Quintile 1**: Least disadvantaged
- **Quintile 2**: Quintile 3: Quintile 4: Quintile 5: Most disadvantaged

**Annual Age-Standardised Mortality Rate per 100,000**

- 1987 to 1991: Rate: 1.57
- 2011 to 2015: Rate: 2.10
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
<table>
<thead>
<tr>
<th></th>
<th>Playford 93,426</th>
<th>Greater Adelaide</th>
<th>South Australia</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander Residents</td>
<td>3.5%</td>
<td>1.4%</td>
<td>2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Median Age</td>
<td>32</td>
<td>39</td>
<td>40</td>
<td>38</td>
</tr>
<tr>
<td>Workforce participation</td>
<td>54%</td>
<td>59%</td>
<td>58%</td>
<td>60%</td>
</tr>
<tr>
<td>Unemployment</td>
<td>13.25%</td>
<td>6.8%</td>
<td>6.9%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Youth</td>
<td>18-25%</td>
<td>--------</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Underemployed</td>
<td>--------</td>
<td>--------</td>
<td>16%</td>
<td>13%</td>
</tr>
<tr>
<td>Welfare dependent families with children</td>
<td>23 %</td>
<td>9.2 %</td>
<td>9.6%</td>
<td>9%</td>
</tr>
<tr>
<td>Children low income welfare dependent families</td>
<td>45.3%</td>
<td>23%</td>
<td>25%</td>
<td>20.9%</td>
</tr>
<tr>
<td>SEIFA</td>
<td>855</td>
<td>989</td>
<td>979</td>
<td>1002</td>
</tr>
</tbody>
</table>
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)
- 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 stakeholders N=28
- One Community residents n=14
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
  “Once you get a change of government, the dynamics change[Playford] is lower socio area and a Labor area”. (Community resident)

- Short-term electoral cycles
  “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)

- New State Government
  “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:

75% GMH - some work
35-40% working full-time
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?
Informal Work

Miriam Vandenberg
Flinders University
@MiriamDVDBerg
#CREHealthEquity
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
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
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)
Micro-theoretical framework of employment conditions and health inequalities (Benach et al 2006)
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)
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.
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
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
Self-reported health status of informal workers

Frequency distribution for health rating (SF-12) by informal workers, 2018 (n=29) and SA population, 2017 (n=2977)

<table>
<thead>
<tr>
<th>Health status</th>
<th>Study participants</th>
<th>SA population (SAHMRI 2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Very Good</td>
<td>20</td>
<td>25</td>
</tr>
<tr>
<td>Good</td>
<td>35</td>
<td>20</td>
</tr>
<tr>
<td>Fair</td>
<td>30</td>
<td>5</td>
</tr>
<tr>
<td>Poor</td>
<td>5</td>
<td>20</td>
</tr>
</tbody>
</table>

Study participants

SA population (SAHMRI 2018)
Mean SF-12 Physical (PCS) and Mental Component Summary (MCS) scores for informal workers (n=29)
## Informal workplace conditions

<table>
<thead>
<tr>
<th>Physical</th>
<th>Chemical</th>
<th>Ergonomic</th>
<th>Psychosocial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asbestos dust</td>
<td>Cleaning chemicals</td>
<td>Long hours</td>
<td>Invisibility</td>
</tr>
<tr>
<td>Clay dust</td>
<td>Horticultural chemicals</td>
<td>Prolonged standing/walking/running or static positions</td>
<td>Job insecurity</td>
</tr>
<tr>
<td>Sun and heat exposure</td>
<td></td>
<td>Lack of breaks</td>
<td>Not paying tax</td>
</tr>
<tr>
<td>Loud noise</td>
<td></td>
<td></td>
<td>Low pay and lack of entitlements</td>
</tr>
<tr>
<td>Sharp objects</td>
<td></td>
<td></td>
<td>Unfair power relations</td>
</tr>
<tr>
<td>Construction materials</td>
<td></td>
<td></td>
<td>Irregular work hours</td>
</tr>
<tr>
<td>Heavy objects</td>
<td></td>
<td></td>
<td>Misrepresenting work activities</td>
</tr>
<tr>
<td>Heights</td>
<td></td>
<td></td>
<td>Violence</td>
</tr>
<tr>
<td>Workplace equipment (e.g. sewing machine, hot appliances)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence and physical encounters</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contaminated waste</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological matter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health</td>
<td>Mental Health and Social Wellbeing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back, shoulder, neck and knee pain (in some cases, arthritis) and other bodily</td>
<td>Anger issues (intermittent explosive disorder)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pain</td>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathlessness (associated with anxiety)</td>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concussion</td>
<td>Isolation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electric shocks to the body</td>
<td>Mental distress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enuresis / encopresis</td>
<td>Night terrors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye irritation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot pain and plantar fasciitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache (sometimes associated with mental distress)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperactivity and insomnia (sometimes associated with mental distress)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalation of hazardous substances (e.g. asbestos, clay dust)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint dislocation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Puncture wounds, cuts and burns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin and eye irritation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sprains, torn muscles, sciatica and bruising</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.
Paid Parental Leave

Dr Belinda Townsend
Australian National University
@BelTownsend
#CREHealthEquity
Agenda setting for paid parental leave in Australia

Dr Belinda Townsend
NHMRC Centre for Research Excellence in the Social Determinants of Health Equity
School of Regulation and Global Governance, Australian National University
belinda.townsend@anu.edu.au
@beltownsend
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)

Weeks

Mothers

Fathers

Estonia
Slovak Republic
Finland
Hungary
Latvia
Norway
Korea
Czech Republic
Lithuania
Austria
Germany
Japan
Sweden
Slovenia
Poland
Canada
Denmark
Italy
Greece
France
United Kingdom
Belgium
Portugal
Chile
Iceland
Ireland
Australia
New Zealand
Netherlands
Spain
Turkey
Israel
Switzerland
Mexico
United States

OCED, Family database 2019
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

<table>
<thead>
<tr>
<th>Industry/Service</th>
<th>Offers paid parental leave</th>
<th>Does not offer paid parental leave</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electricity, Gas, Water and Waste Services</td>
<td>38.5</td>
<td>61.5</td>
</tr>
<tr>
<td>Education and Training</td>
<td>64.2</td>
<td>35.8</td>
</tr>
<tr>
<td>Financial and Insurance Services</td>
<td>73.3</td>
<td>26.7</td>
</tr>
<tr>
<td>Information Media and Telecommunications</td>
<td>61.9</td>
<td>38.1</td>
</tr>
<tr>
<td>Professional, Scientific and Technical Services</td>
<td>61.7</td>
<td>38.3</td>
</tr>
<tr>
<td>Health Care and Social Assistance</td>
<td>59.0</td>
<td>41.0</td>
</tr>
<tr>
<td>Other Services</td>
<td>52.8</td>
<td>47.2</td>
</tr>
<tr>
<td>Arts and Recreation Services</td>
<td>51.9</td>
<td>48.1</td>
</tr>
<tr>
<td>Mining</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Public Administration and Safety</td>
<td>40.0</td>
<td>59.1</td>
</tr>
<tr>
<td>Wholesale Trade</td>
<td>34.2</td>
<td>65.8</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>34.1</td>
<td>65.9</td>
</tr>
<tr>
<td>Rental, Hiring and Real Estate Services</td>
<td>33.6</td>
<td>66.3</td>
</tr>
<tr>
<td>Transport, Postal and Warehousing</td>
<td>30.5</td>
<td>69.5</td>
</tr>
<tr>
<td>Agriculture, Forestry and Fishing</td>
<td>25.5</td>
<td>74.5</td>
</tr>
<tr>
<td>Administrative and Support Services</td>
<td>22.9</td>
<td>77.1</td>
</tr>
<tr>
<td>Accommodation and Food Services</td>
<td>22.3</td>
<td>77.7</td>
</tr>
<tr>
<td>Construction</td>
<td>22.1</td>
<td>77.9</td>
</tr>
<tr>
<td>Retail Trade</td>
<td>19.8</td>
<td>80.2</td>
</tr>
<tr>
<td>All Industries</td>
<td>46.0</td>
<td>54.0</td>
</tr>
</tbody>
</table>

Fathers’ and Partners’ PPL

Panel B. Gender distribution of recipients/users of publicly administered parental leave/benefits

Share of users/.recipients (%)
The Iceland example – what’s possible

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
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
#CREHealthEquity
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
Indigenous rights and policy timeline

Timeline created by Emma George
“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
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.
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 Muttitjulu

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

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 Akelyernemanene Meke Mekarie - Little Children Are Sacred report from the Inquiry released, with 97 recommendations

30 April 2007
Inquiry report submitted to Clare Martin

10 July 2007
Combined Aboriginal Organisations of the Northern Territory publish an Alternative Plan

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

---

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

By political editor Andrew Probyn

Posted Fri at 3:46pm
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
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.”
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.”
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.”
Close the Gap

Associate Professor Tamara Mackean and Dr Matt Fisher
Flinders University
#CREHealthEquity
Closing the Gap 2008 – 2018
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
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
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
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
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”
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”
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

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
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”
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.”
National political and policy environment

Partnership Agreement on Closing the Gap 2019–2029

Indigenous Evaluation Strategy
Productivity Commission Issues Paper
June 2019

Close the Gap

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

The Redfern Statement 2016

The Lowitja Institute

NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PLAN 2013–2023

The Hon Ken Wyatt AM MP
Minister for Indigenous Australians
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

A framework to assess cultural safety in Australian public policy
**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:**

<table>
<thead>
<tr>
<th>Political environment</th>
<th>National truth telling and Makarrata Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda setting</td>
<td><strong>Constitutional recognition</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation structures &amp; processes</th>
<th>COAG Partnership Agreement on Closing the Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revised CTG targets, PM’s annual report</td>
</tr>
</tbody>
</table>
**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 | • *Voice to Parliament*  
| Agenda setting | • 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 |
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* |
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 | • Constitutional recognition  
| Agenda setting | • 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  

---

*Flinders University*
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:

<table>
<thead>
<tr>
<th>Political environment</th>
<th>• Makarrata Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agenda setting</td>
<td></td>
</tr>
</tbody>
</table>
| 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 |
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
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’

‘Doubles’ (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
What have we learnt about actions for health equity?

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

@SharonFrielOz  
#CREHealthEquity
1. Data, knowledge, evidence
2. Structure – agency - Power
3. Relationships and commitment
Data, Evidence, Knowledge
THE ‘WHY’
Describing the problem

THE ‘HOW’
A. 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

Spaces and levels

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

Forms of power

- Structural
- Instrumental
- Discursive
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  evidence
F  framing strategically
F  forum shop
E  external and internal policy processes
C  coalition building
T  targeted 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

Rising political consciousness
Collective action
Organised strategy

CRE CPRG
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*
Questions
SESSION 5
Advocacy Ideas Panel

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