Social Determinants of Health

2020

Note

The AMA Position Statement on *Social Determinants of Health 2020* was finalised and endorsed by the AMA Federal Council in early 2020, shortly before the novel coronavirus (COVID-19) was declared a global pandemic, and its impacts began to be felt in Australia.

Since then, more than 65 million COVID-19 infections have been diagnosed worldwide, and more than 1.5 million people have died. Australia has done well to control the infections, but we have still had more than 27,000 cases, and more than 900 deaths – largely among our most vulnerable people.

While this Position Statement's release has been delayed, its recommendations not only remain valid, but have been reinforced by the disproportionate effect that the pandemic is having on the disadvantaged in our community, including those already experiencing poverty, health inequities, disability, and discrimination. The AMA urges Australian governments to consider the additional impacts of COVID-19 on the social determinants of health, and in particular, the financial disadvantages that have been exacerbated by the pandemic. Australia has a new cohort of unemployed people arising from the events of 2020, which impacts communities in other areas including mental ill-health and domestic violence. This year has revealed the essential nature of front-line services in providing support to areas of high need in times of crisis in particular. The AMA will review this Position Statement within 12 months of its publication to account for the impacts of the COVID-19 pandemic on the social determinants of health.

While lockdowns are easing around the nation, the second wave of infections in Victoria and smaller outbreaks in other jurisdictions show that complacency is COVID-19's best ally, and our worst enemy. The 2020 Federal Budget, while maintaining financial supports, relies heavily on the assumption that an effective and universally available vaccine is in sight, and that our borders and our economy will reopen in coming months. However, it is clear that even if the most optimistic forecasts come true, the ongoing impact of this year's disruption will have long-lasting effects on those who have lost income and working hours, had their access to education cut off, and are in vulnerable accommodation.

The AMA continues to maintain that social distancing should and will be part of our lives for some time yet, as we do not know how effective the vaccines under development are going to be. Understanding this through the lens of social determinants reminds us that basic housing, hygiene, safety and access to clean water are essential to keeping healthy and COVID-19 free. During the early part of any rollout, the limited available vaccine will need to be prioritised to higher needs groups within the community.

Social determinants of health remind us of the challenges some groups in our community face to access the basic health care they need. The AMA acknowledges those communities will need extra assistance from a responsive health system as we adapt to the necessary changes brought about from COVID-19.

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A person's health is shaped by the social, economic, cultural and environmental conditions they live in. Health inequities typically arise because of inequalities within society. Health inequities are avoidable and can be associated with forms of disadvantage such as poverty, discrimination, and access to goods and services.[1] In order to achieve health equity, we must not only focus on treating disease and modifying risk factors, we must focus on the underlying social determinants of health that influence population health and wellbeing. Improving the overall health of the population, and reducing health inequities, should be a core focus of the Australian health system.

AMA Position

The AMA calls on the Commonwealth government to:

1.1 Prioritise efforts to address health inequities in the social determinants of health for Aboriginal and Torres Strait Islander peoples;

1.2 Prioritise action on the social determinants of health in the National Preventive Health Strategy;

1.3 Adopt a whole of government approach to address the social determinants of health by establishing a cross portfolio Ministerial body to consider and provide advice on policies that may impact on health outcomes and health equity;

1.4 Ensure that all tiers of government take a more proactive role in addressing the social determinants of health, including regular public reporting on progress, and health equity assessments of relevant policies;

1.5 Ensure that national research funding bodies (including the National Health and Medical Research Future Fund, the Australian Research Council, and the National Health and Medical Research Council) commit to funding research into prevention and population health;

1.6 Recognise the window of opportunity to alter long term health by positively influencing infant and child development and health, and adopt a universal approach to evidence-based health promotion and prevention and early intervention programs, including pre-pregnancy counselling to ensure every child has the best start in life;

1.7 Work collaboratively with State and Territory Education Departments to improve health literacy;

1.8 Ensure that all individuals have access to means that support adequate standards of living, regardless of their participation in paid employment and invest in measures that support re-training and re-employment for those who are affected by underemployment or unemployment;

1.9 Recognise the contribution of the social determinants of health as they apply to drug and alcohol misuse, including investment in interventions that seek to reduce their impact as opposed to reliance.

The AMA calls on State and Territory governments to:

2.1 Prioritise efforts to address health inequities in the social determinants of health for Aboriginal and Torres Strait Islander peoples;

2.2 Recognise the window of opportunity to alter long term health by positively influencing infant and child development and health, and adopt a universal approach to evidence-based health promotion and prevention and early intervention programs, including pre-pregnancy counselling to ensure every child has the best start in life;

2.3 Prioritise action on the social determinants of health in State and Territory prevention or population health plans or strategies;

2.4 Designate responsibility for action on the social determinants of health to Premiers' or Chief Ministers' departments and include provisions for cross portfolio collaboration;

2.5 Invest in measures that improve health literacy;

2.6 Continue investment and commitment to diversion programs that reduce or eliminate incarceration, detention and recidivism;

2.7 Recognise nutrition as a social determinant of health, including investment in approaches that ensure affordable and nutritious food for all, including priority groups such as children, adolescents, and older persons.

The AMA calls on members of the medical profession to:

3.1 Be cognisant of the social determinants of health and the influence they have on a patient's health and wellbeing;

3.2 Regularly assess their own practice to ensure that treatment decisions contribute to achieving health equity for both individuals and communities;

3.3 Encourage organisations involved in medical education to develop and implement policies that support the entry to and completion of medical studies by students from diverse groups;

3.4 Advocate for education about the social determinants of health to be included in the curriculum of undergraduate or postgraduate medical school programs and in College-based training programs;

3.5 Support increased awareness of health inequities and potential for bias in medical treatment decisions by engaging practitioners in open discussions about the issue in a range of settings including medical school, medical Colleges and professional societies, medical journals, professional conferences, and as part of professional peer review activities.

Definitions

Social Determinants of Health
The World Health Organization describes the social determinants as '*the circumstances in which people grow, live, work and age and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social and economic forces'*.[2] The social determinants of health include a range of factors such as geographic location, income, education, employment, and social support.

Health inequality
Health inequality refers to the systematic differences in health between groups.[3]

Health inequity
Health inequity refers to the differences in health which are unfair, unjust, systematic, avoidable and/or unnecessary.[3]

Further Background

Many Australians enjoy good health. As a nation, Australia is typically listed among the top 10 by the Organisation for Economic Cooperation and Development (OECD) when measuring a range of health indicators including life expectancy.[4] Over half of Australian residents report their own health to be very good or excellent. However, some Australians, particularly Aboriginal and Torres Strait Islander peoples, suffer much poorer health compared to the rest of the population. The gap is profound and unacceptable.

Widely accepted social determinants of health include:

- Socioeconomic status;
- Nutrition;
- Early life experience;
- Education;
- Social exclusion;
- Employment status;
- Housing;
- Cultural determinants;
- Natural, built and physical environments;
- Social security; and
- Transport.

While there is strong evidence that health system spending contributes to better health outcomes,[5] it has also been recognised that almost half of an individual's overall health and wellbeing can be attributed to socioeconomic factors.[6] Measuring the precise health impacts of investments outside the health domain can be difficult, but it is clear that some of the biggest improvements for people at risk of poor health outcomes derive from addressing the social determinants of health, including housing, social care, and isolation.[7]

Action on the social determinants of health is an appropriate way to address avoidable health inequalities.[8] The World Health Organization's Commission on Social Determinants of Health made recommendations about the importance of closing the gap in health outcomes by addressing the social determinants of health. The WHO recommends a 'whole of government' approach that recognises the impact of policies in a range of portfolio areas, and the subsequent impacts on health.

Recommendations include:

- Give every child the best start in life;
- Enable all children, young people and adults to maximise their capabilities and have control over their lives;
- Create fair employment and good work for all;
- Ensure a healthy standard of living for all;
- Create and develop healthy and sustainable places and communities; and
- Strengthen the role and impact of ill-health prevention.

Tackling the problem appropriately

The obvious discrepancies in mortality are compelling enough to justify concerted action on the social determinants of health. However, there is also a strong economic argument. A healthier workforce is more productive, which can increase economic growth rates over the long term and raise a country's standard of living.

Modelling has indicated that if Australia adopted the World Health Organization's recommendations, the potential benefits would include:

- 500,000 Australians could avoid suffering a chronic illness;
- 170,000 extra Australians could enter the workforce, generating $8 billion in extra earnings;
- Annual savings of $4 billion in welfare support payments could be made;

- 60,000 fewer people would need to be admitted to hospital annually, resulting in savings of $2.3 billion in hospital expenditure;
- 5.5 million fewer Medicare services would be needed each year, resulting in annual savings of $273 million;
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in annual savings of $184.5 million each year.[9]

It is unlikely that we will eliminate the influence of the social gradient in health entirely but there is evidence that the degree of the gradient can be reduced. Universal and targeted approaches have potential strengths and challenges. Universal approaches do not always capture the most vulnerable and may contribute to improved outcomes for those already in advantageous positions. Targeted approaches may address consequences of inequities rather than the causes.[10]

Targeted universalism defines goals for all, identifies obstacles faced by specific groups, and tailors strategies to address the barriers in those situations.[11] Proportionate universalism is a widely supported approach that recognises policies and programs must include a range of responses for different levels of disadvantage, aiming to improve the health of the whole population, while simultaneously improving the health of the most disadvantaged fastest. These newer hybrid approaches are being used internationally with some success and warrant consideration in Australia.

A healthy population is a key goal for all societies. Reducing inequalities and the angle of the social gradient improves health and wellbeing for everyone. Good health improves work productivity, increases the capacity for learning, supports sustainable environments, empowers families and communities, and reduces poverty and social exclusion. All public policies should be considered through an equality and health equity lens.

Priority groups

There are groups within the population that experience disadvantage and higher rates of illness and premature death than the general population. Social and economic factors are estimated to account for slightly more than one third (34 per cent) of the 'good health gap'. Health risk factors (such as high blood pressure, smoking, and risky alcohol consumption) also contribute to the discrepancy.

These disadvantaged groups include (but are not limited to) Aboriginal and Torres Strait Islander peoples, people who live in rural and remote areas, people with disability, people living with mental illness, single parents and newly arrived migrants. People who fall into more than one of these groups may experience increased disadvantage. The impacts of chronic disease may be felt more acutely within these vulnerable groups, not only in relation to prevalence of disease or health condition, but also in terms of earlier onset, greater severity, and greater complexity in management.[12]

In Australia, the 'social gradient of health' manifests in a range of ways, including:

- The 20 per cent of Australians living in the lowest socio-economic areas were 1.6 times more likely as the highest 20 per cent to have at least two chronic health conditions;
- Australians living in the lowest socio-economic areas lived about 3 years less than those living in the highest area;
- People reporting the worst mental and physical health were twice as likely to live in poor quality or overcrowded dwellings;
- Mothers in the lowest socio-economic areas were 30 per cent more likely to have a low birthweight baby than mothers in the highest socio-economic areas;
- A higher proportion of people with an employment restriction due to a disability lived in the lowest socio-economic areas (26 per cent) than in the highest socio-economic areas (12 per cent);
- Unemployed people were 1.6 times more like to use cannabis, 2.4 times as likely to use meth/amphetamines and 1.8 times more likely to use ecstasy than employed people;
- Dependent children living in the lowest socio-economic areas were 3.6 times more likely to be exposed to tobacco smoke inside the home as those living in the highest socio-economic areas (7.2 per cent, compared with 2 per cent);

- People in low socio-economic resource households spend proportionally less on medical and health care than other households;
- People living in the lowest socio-economic areas were more than twice as likely to delay seeing, or not see, a dental professional due to cost compared with those living in the highest socio-economic areas (28 per cent compared with 12 per cent). [13]

Further, a recent analysis of cardiovascular disease (CVD), diabetes, and chronic kidney disease confirmed:

- Males living in the lowest socio-economic areas of Australia had a heart attack rate 1.55 times higher than males living in the highest socio-economic areas. For females, the disparity was even greater at 1.76 times higher;
- The prevalence of Type 2 diabetes for females in the lowest socio-economic area was 2.07 times higher than those in the highest socio-economic areas, for men the prevalence was 1.07 times;
- The rate of end stage kidney disease for males in the lowest socio-economic areas was 1.52 higher than males in the highest socio-economic areas, for females it was 1.75 times higher;
- If all Australians had the same CVD death rates as people in the highest socio-economic areas, the total CVD rate would have declined by 25 per cent and there would have been 8,600 fewer deaths.

Aboriginal and Torres Strait Islander peoples generally experience significantly worse health outcomes compared with the non-Indigenous population.[14] Research confirms the importance of social determinants in understanding and addressing this gap. A 2009 analysis concluded that up to one third of the difference in life expectancy can be attributed to differences in the social determinants.[15] When considering the contribution of individual variables, household income, highest level of schooling and employment status have been shown to make the largest impact on reducing the health gap.

In 2007, the Council of Australian Governments committed to 'Closing the Gap' in life expectancy for Aboriginal and Torres Strait Islander people by 2030. Targets were set within the domains of health, education, and employment, with dedicated investments directed towards achieving those targets. As of 2019, two of the seven targets are on track to be achieved.[16] Recognising these shortcomings, and the potential benefit of targets in other areas, in 2019 the Government entered into an historic partnership with Aboriginal and Torres Strait Islander community-controlled organisations, known as the Coalition of Peaks, to overcome the entrenched inequality faced by many Aboriginal and Torres Strait Islander peoples. This partnership is formalised through the National Agreement on Closing the Gap which came into effect on 27 July 2020. The National Agreement is centred around four priority reform areas to accelerate improvements in the lives of Aboriginal and Torres Strait Islander peoples; shared-decision making between governments and Aboriginal and Torres Strait Islander peoples, building the community-controlled heath sector, improving the ability of government organisations to respond appropriately to the needs of Aboriginal and Torres Strait Islander peoples and shared access to data and information at a regional level.

While efforts are being made to reduce overt racism from many institutional settings in Australia, covert forms of racism continue to exist. This undermines efforts to achieve equity in health and other outcomes. For more information please refer to the AMA's Anti-Racism statement.

It is also likely that future efforts to reduce the gap in health outcomes will incorporate and emphasise the role of culture. The notion of cultural determinants and culture as a domain that can positively impact on health is relatively recent.[17] The cultural determinants stress the need for protection and promotion of traditional knowledge, family, culture and kinship and their contributions to community cohesion and personal resilience. Research shows that strong cultural links and practices not only improve outcomes across the social determinants of health but empower those people to own and direct those health improvements.[18]

Concerns are also being raised about the failure to engage Aboriginal and Torres Strait Islander peoples in decisions that are relevant to them. Constitutional reform that enshrines the voice of Aboriginal and Torres Strait Islander peoples via a Parliamentary advisory body is reflected in *The*

Uluru Statement from the Heart. The AMA's Federal Council endorses the Statement and calls on the Australian Government to do the same.

The conditions in which children live and grow can have an extensive impact on their current and future health. The first 1000 days of life are increasingly recognised as an important and sensitive period of development, during which a number of vital skills and abilities develop, and represent a high value target to address health inequities arising from social determinants of health.[19]

Children's health is inextricably linked to that of their families, and the impact of social determinants of health is mediated through their familial context.[20] For example, in families where there is low income or financial distress, it may be difficult to balance costs associated with adequate food, housing, clothing and medical care, and this limits young people's capacity to achieve higher levels of education. Exposure to trauma (through homelessness, domestic violence, parental substance abuse and mental ill health) can have profound and enduring consequences, resulting in poorer physical[21] and mental[22] health across the lifespan[23]. Recognising this, efforts to increase supports for parents and children during this period should be a priority for all governments. However, it is also important to note that efforts to support the first 1000 days do not replace the need to support older children and adolescents who remain vulnerable to the influences of the social determinants of health within and outside their family, and warrant specific services and supports.

Stronger action is required to break the endemic cycles of poverty and intergenerational trauma that perpetuate inequity and poor health outcomes in families and communities across Australia, from the very start of life.

The role of the medical profession

All medical practitioners have a responsibility to address inequity in their work.

While upstream and midstream determinants influence the type, likelihood, number and severity of disease that affect a person, downstream inequities come into play when a person becomes ill. They occur at many levels, for example:

- Barriers to access to a primary care medical practitioner due to cost or the lack of health services and doctors which are typically fewer in lower socio-economic areas;
- Communication barriers;
- Inability to afford optimal form of treatment;
- Less likely to be referred to rehabilitation services, and
- Government policies not to provide, or to restrict access to, services.

There are practical ways that doctors can advocate for action in healthcare settings and the community, as well as by influencing local and national policy. Actions that can be undertaken in the healthcare setting include the following:

- Improving health literacy across the population through the provision of information and referral to suitable sources of additional information;
- Facilitating referral to non-medical sources of support within the community;
- Developing local strategies to improve access to health services for vulnerable groups;
- Encouraging healthcare organisations to assess the impact of policy changes on health inequalities;
- Considering becoming an advocate for community action.[24]

The role of governments

Many policy areas outside of the health portfolio can strongly influence health outcomes. Transport, housing, fiscal and employment policies are examples ofgovernment policies that can support or undermine health.[25] Many contemporary public health problems, such as childhood obesity, arise from complex situations involving a number of different policy sectors. Broad-based action is needed to improve the social, environmental, economic and commercial conditions in which people live.

Recognising this, the World Health Organization has called on governments to refocus their public health policies to ensure action by all sectors of government to address 'the causes of the causes' in order to improve population health.[26]

Unfortunately, the reality is that governments do not always pursue opportunities to improve health through non-health policy levers. This may be because impacts on health are not routinely considered in the development of policies in different sectors, and even in instances when they are considered, the relationships and associations between certain policy measures and outcomes can be difficult to untangle and explain. It is possible that the delay between the implementation of a policy measure and changes in health outcomes also contributes to this. It is also worth noting that within the Australian context, all three tiers of government have jurisdiction over measures that can influence health.

In recent decades, international efforts to support all countries to better account for the impacts of policies on health, poverty and the environment have arisen. In 2000, 191 United Nations members committed to eight international development goals for the year 2015, also referred to as the Millennium Development Goals (MDGs). For 15 years, the MDGs facilitated progress in many areas including reducing income poverty, providing access to water and sanitation, reducing child mortality, improving maternal health, and significant improvements in combatting HIV / AIDS and other treatable diseases such as malaria and tuberculosis.[27]

More recently, the MDGs have been replaced by 17 interconnected Sustainable Development Goals (SDGs) that affirm international commitments to end poverty in a sustainable and climate-friendly way. All 17 SDGs are connected, meaning that progress and success in one area influences progress and success in other areas. The SDGs are reflected in the 2030 Agenda for Sustainable Development which has been adopted by the 193 countries of the UN General Assembly (including Australia).

A recent report from the Sustainable Development Council[28] assessed local Australian data and found that 35 per cent of the SDGs were 'on track', 23 per cent needed improvement, 18 per cent needed a breakthrough to be achieved and 24 per cent were 'off track'. Further, the report asserted that Australia was performing relatively well in health (SDG 3) and education (SDG 4), but that failures to reduce inequalities (SDG 10) and engagement with climate action (SDG 13) were notably poor and that considerable progress was required. The Australian Government must seek to address all SDGs as part of its commitment to the UN's 2030 Agenda for Sustainable Development.

Health in All Policies

'Health in all policies' (HiAP) is an established approach to improving health and health equity through concerted inter-sector action on the wider determinants of health. It aims to embed health and health equity considerations across sectors, policies, and service areas. In addition to improving health and health equity, HiAP partnerships can support non-health sectors to achieve their own goals such as creating good quality jobs or economic stability. At the same time, a healthier population is likely to bring social and economic benefits to other sectors in the long term.[29]

There are international examples of HiAP approaches, including the North Karelia Project in Finland which reduced the prevalence of heart disease through engagement with a number of non-health sectors including community organisations and food producers. The South Australian Government has also been recognised as an example of HiAP in action. Much of the success of the approach in South Australia has been attributed to ensuring clear governance and accountability structures, and incorporation of the 'health lens' process which includes consideration of the co-benefit approach.

The *Adelaide Statement on Health in All Policies* emphasises the importance of cross sector collaboration to improve health and wellbeing, as well as providing more detailed advice for the health sector to facilitate this work (including reference to a range of tools and instruments that are useful). This Statement provides a template for continued action in this area.[30,31]

References

1. Whitehead, M. (1992). The concepts and principles of equity and health. *International Journal of Health Services* 22(3):429–45.
2. CSDH (Commission on Social Determinants of Health) 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: WHO
3. The Royal Australasian College of Physicians. Health in All Policies Position Statement. December 2016. Accessed from: https://www.racp.edu.au//docs/default-source/advocacy-library/health-in-all-policies-position-statement.pdf?sfvrsn=4bd1391a_4
4. OECD: Health at a Glance 2017: OECD Indicators. Available from: http://www.oecd-ilibrary.org/docserver/download/8117301e.pdf?expires=1518048517&id=id&accname=guest&checksum=66AD41BDB5EE4B2A5506508F015B3241
5. Cylus, J., Permanand, G. & Smith, P. (2018). Policy Brief. Making the economic case for investing in health systems: What is the evidence that health systems advance economic and fiscal objectives? World Health Organization Regional Office for Europe. Accessed from: http://www.euro.who.int/__data/assets/pdf_file/0010/380728/pb-tallinn-01-eng.pdf?ua=1
6. Hood, C., Gennuso, K., Swain, G. & Caitlin, C. (2016). Country Health Rankings: Relationship between determinant factors and health outcomes. Am J Prev Med; 50(2) pp 129-135. Accessed from: https://www.ncbi.nlm.nih.gov/pubmed/26526164
7. Sustainable Health Review. (2019). Sustainable Health Review: Final Report to the Western Australian Government. Department of Health, Western Australia. Accessed from:https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/Sustainable%20Health%20Review/Final%20report/sustainable-health-review-final-report.pdf
8. Australian Institute of Health and Welfare 2018. Australia's health 2018. Australia's health series no. 16. AUS 221. Canberra: AIHW. Accessed from: https://www.aihw.gov.au/getmedia/7c42913d-295f-4bc9-9c24-4e44eff4a04a/aihw-aus-221.pdf.aspx?inline=true
9. Brown, L., Thurecht, L., Nepal, B. (2012) The cost of inaction on the social determinants of health. Report No.2/2012. CHA-NATSEM Second Report on Health Inequalities. Catholic Health Australia. Available from: http://www.natsem.canberra.edu.au/storage/CHA-NATSEM%20Cost%20of%20Inaction.pdf
10. National Collaborating Centre for Determinants of Health. (2013). Let's talk: Universal and targeted approaches to health equity. Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University. Accessed from: http://nccdh.ca/images/uploads/Approaches_EN_Final.pdf
11. Powell J. Structural Fairness & Targeted Universalism: Reflections on Detroit [internet]. Berkeley: University of California. 2012 [cited 2013 February 4]. Accessed from: https://haasinstitute.berkeley.edu/structural-fairness-targeted-universalism-reflections-detroit
12. Australian Institute of Health and Welfare 2019. Indicators of socioeconomic inequalities in cardiovascular disease, diabetes and chronic kidney disease. Cat. no. CDK 12. Canberra: AIHW. Accessed from: https://www.aihw.gov.au/getmedia/01c5bb07-592e-432e-9fba-d242e0f7e27e/aihw-cdk-12.pdf.aspx?inline=true
13. Australian Institute of Health and Welfare 2016. Australia's health 2016. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW. Accessed from: https://www.aihw.gov.au/getmedia/11ada76c-0572-4d01-93f4-d96ac6008a95/ah16-4-1-social-determinants-health.pdf.aspx
14. Australian Institute of Health and Welfare 2014. Australia's health 2014. Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW. Available from: https://www.aihw.gov.au/getmedia/d2946c3e-9b94-413c-898c-aa5219903b8c/16507.pdf.aspx?inline=true
15. DSI Consulting Pty Ltd & Benham D 2009. An investigation of the effect of socio-economic factors on the Indigenous life expectancy gap. Canberra: DSI Consulting Pty Ltd.
16. Department of Prime Minister and Cabinet. (2019). Closing the Gap Report 2019. Available from: https://www.niaa.gov.au/sites/default/files/reports/closing-the-gap-2019/sites/default/files/ctg-report-20193872.pdf.

17. The Lowitja Institute. (2014). Cultural Determinants Roundtable: Background paper. Available from: https://www.lowitja.org.au/sites/default/files/docs/Cultural-Determinants-Roundtable-Background-Paper.pdf
18. Professor Ngaire Brown, University of Wollongong, Keynote Presentation to 2013 NACCHO Aboriginal Community Controlled Health Service Summit
19. Moore, T.G., Arefadib, N., Deery, A., & West, S. (2017). The First Thousand Days: An Evidence Paper. Parkville, Victoria; Centre for Community Child Health, Murdoch Children's Research Institute. Accessed from: https://www.rch.org.au/uploadedFiles/Main/Content/ccchdev/CCCH-The-First-Thousand-Days-An-Evidence-Paper-September-2017.pdf
20. Australian Institute of Health and Welfare 2019. Australia's children—in brief Cat. no. CWS 72. Canberra: AIHW.. Accessed from: https://www.aihw.gov.au/reports/children-youth/australias-children-in-brief/contents/table-of-contents
21. Tosevski, D.L. & Milovanecevic, M.P. (2006). Stressful life events and physical health. *Current Opinion in Psychiatry, 19(2):* 184-189. Accessed from: https://journals.lww.com/co-psychiatry/Abstract/2006/03000/Stressful_life_events_and_physical_health.13.aspx
22. Margolin, G. & Vikerman, K.A. (2007). Post-traumatic stress in children and adolescents exposed to family violence: Overview and issues. Prof Psychol Res Pre, 38(6): 613-619. Accessed from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3806884/https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2811337/
23. Ogle, M., Rubin, D.S. & Siegler, I.C. (2013). The impact of the developmental timing of trauma exposure on PTSD symptoms and psychosocial functioning among older adults. Dev Psychol., 49(11).
24. British Medical Association (2016). Health in all policies: health, austerity and welfare reform. A briefing from the board of science. Available from: https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/improving%20health/public%20and%20population%20health/bos-health-in-all-policies-austerity-briefing-2016.pdf?la=en
25. The Health Foundation (2019). Implementing health in all policies: Lessons from around the world. Accessed from: https://www.health.org.uk/sites/default/files/upload/publications/2019/Implementing%20health%20in%20all%20policies.pdf
26. World Health Organization (WHO). Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. WHO, Geneva, 2008, p. 42. Accessed from: https://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf
27. United Nations Development Programme. Sustainable Development Goals – Background. Accessed from: https://www.undp.org/content/undp/en/home/sustainable-development-goals/background.html
28. The National Sustainable Development Council. SDG Progress Report. Accessed from: https://www.sdgtransformingaustralia.com/#/2772/1369//
29. The Health Foundation (2019). Implementing health in all policies: Lessons from around the world. Accessed from: https://www.health.org.uk/sites/default/files/upload/publications/2019/Implementing%20health%20in%20all%20policies.pdf
30. World Health Organization. 2010. Adelaide Statement on Health in All Policies: Moving towards a shared governance for health and well-being. Accessed from: https://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf
31. World Health Organisation. 2017. Adelaide Statement 2: Outcome Statement from the 2017 International conference *Health in All Policies: Progressing the Sustainable Development Goals*. Accessed from: https://www.who.int/social_determinants/SDH-adelaide-statement-2017.pdf?ua=1