The Role of Local Government in Addressing the Social Determinants of Health

MAV MacArthur Local Government Fellowship Award 2015 Final Report

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Declaration: I declare this report to be my own work alone except where other authors and/or documents are referenced.

Contents

Executive summary

Social determinants of health, as its name suggests, refers to the non-medical factors that impact on one's health and wellbeing. There is considerable literature on the importance of factors such as housing, education, employment status and environment and their influence one's health and wellbeing.

Councils have been historically at the forefront of addressing social determinants of health through their roles in sanitation, public utilities and transport infrastructure. Over time, councils have taken on additional social and public health initiatives aimed at improving the overall health status of their resident. These included the provision of libraries, child and maternal health care centres, youth services, aged and community care but to name a few. In recent years, there has been increased focus on social and affordable housing, better built environment, employment opportunities for youth and the disadvantaged and local economic development. It can be argued therefore, that councils are at the centre of addressing the social determinants of health of their residents.

As part of the MacArthur Fellowship, the author travelled to England, Denmark, Sweden, Belgium and Singapore in order to gain more insight and understanding of how local governments in these countries are addressing the social determinants of health for their citizens, and to see if there are elements of best practice that can be adopted in Victoria and perhaps in other states as well.

The report is written in the chronological order in which the author undertook the study. The main elements of best practice in addressing the social determinants of health at local government levels are as follow:

1. Recognising and embedding a health in all policies approach in policy and program development.
2. Adopting a long term political commitment towards reduce inequalities in communities.
3. Meaningful, up-to-date and localised data is a powerful tool for service planning and delivery of targeted interventions.
4. Collaboration is the key. This will enhance staff knowledge and understanding of the social determinants of health and improve intra and inter agency communication, leading to sustainable outcomes for the community.
5. Be ambitious and prepare to lead.

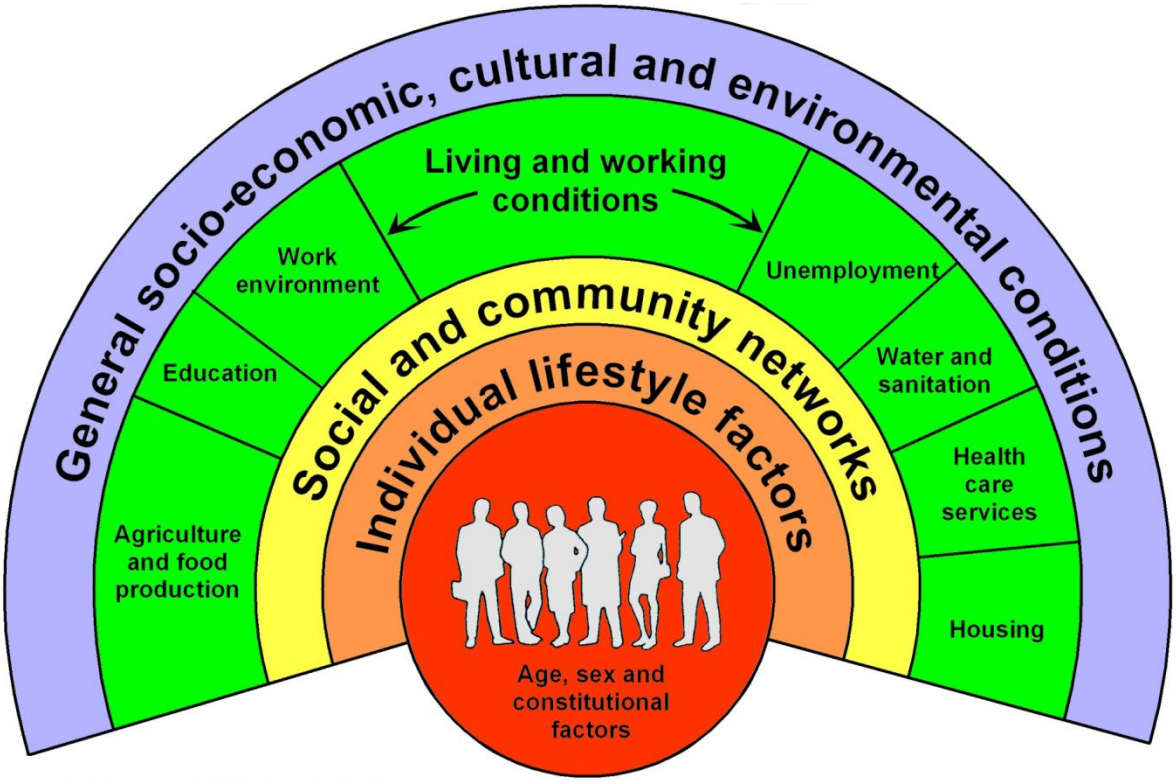
The author also argues for a review and possible amendment of the Victorian Public Health and Wellbeing Act (2008) in order to make tackling social inequalities a priority. The establishment of Health and Wellbeing boards, broadly based on their English counterparts, will bring about closer collaboration between the State and local governments. This, in turn, will facilitate greater shared understanding of the roles of both levels of government in addressing the social determinants of health of citizens.

Introduction

Local governments are often considered to be 'closest to the people' not only because of the range of services they provide to various local community groups, but also because of the effect of these service on community wellbeing. Collectively, these services impact on the social determinants of health of residents.

The World Health Organisation (WHO) defines the social determinants of health as "*the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels*"[1]. In other words, the communities in which individuals live, work and socialise directly contributes towards one's health and ill health.

There is a growing body of scientific evidence that demonstrates that one's health status and health outcomes, particularly in relation to lifestyle factor diseases such as diabetes, are heavily influenced not only by medical and genetic factors, but also by the social determinants of health in which individuals find themselves in. Factors such as safe and secure housing, access to education and information, meaningful employment and community connectedness can all contribute toward the positive health outcomes of individuals. The reverse is also true, lack of housing, unemployment, education and social isolation all have detrimental effects on one's health. This is best illustrated below



Source: Dahlgren and Whitehead, 1991

[1] http://www.who.int/social_determinants/en/

Local governments are intimately involved in addressing many, if not all, social determinants of health, directly or indirectly. While the most obvious aspect of this is the legislative requirement for Victorian councils to produce their health and wellbeing plans, other aspects of council operations can also influence and impacts on individuals' health. These include, but not limited to:

- Urban planning: adequate access to open space and areas for social gathering;
- Road and transport: accommodating multimodal transport (walking, cycling, public and private transport) and minimise hazards through passive road safety measures;
- Children's services: immunisation and child and maternal health nurse, mothers' groups to increase health literacy and to minimise social isolation and post-natal depression;
- Libraries: as centres of learning and accessing information, and as community spaces for socialisation and events;
- Youth services: employment and support services, access to health information and services without the stigma associated with traditional health centres and clinics (e.g. mental health, sexual/reproductive health, drug and alcohol);
- Migrant/asylum seekers services: accessing social and health information in non-traditional settings;
- Sporting clubs and playgrounds: encouraging active sports and recreation but also builds social inclusiveness and breaking down barriers for people experiencing disadvantage.

One major drawback for local governments in intervening on the social determinants of health is the lack of systematic and detailed understanding of best practice models and critical success factors for local government in addressing social determinants of health factors.

The WHO definition of social determinants of health provided above can be examined in the context of social equity and inclusion. Specifically, it can be argued that addressing social equity as an overarching objective in provision of council services and infrastructure may be beneficial in the long term health and wellbeing outcome of residents.

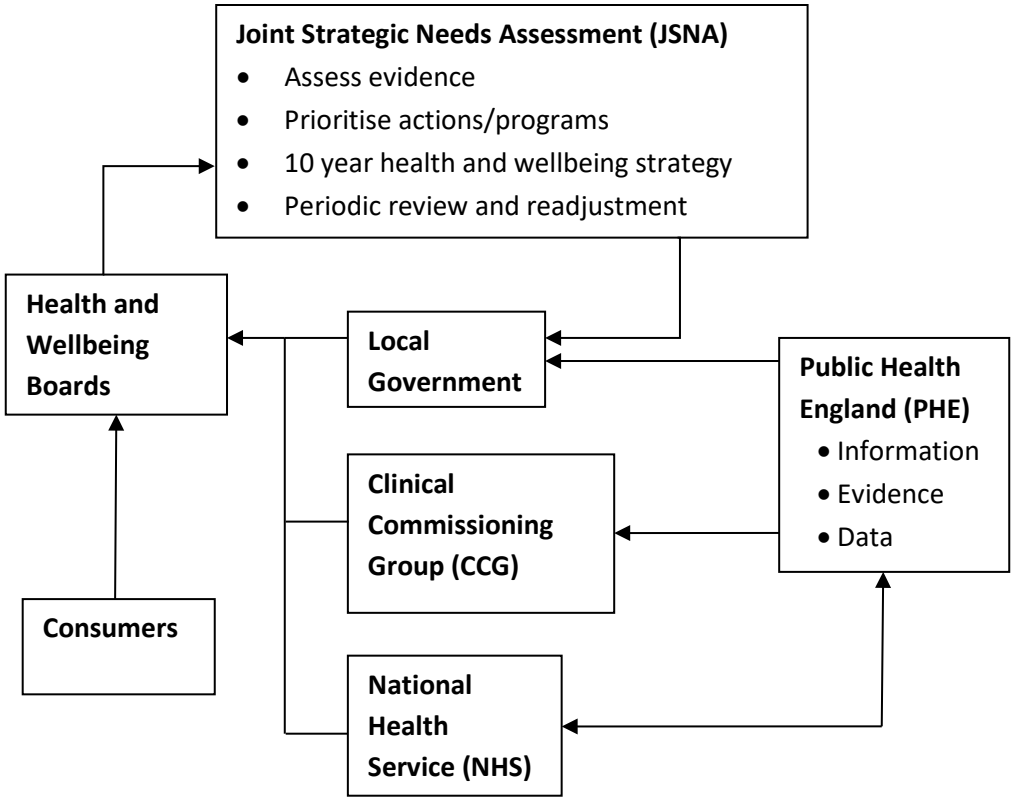
As part of the MAV MacArthur fellowship award, the author visited England, Denmark, Sweden, Belgium and Singapore. The following report will detail findings and implications for Victorian councils as a result of the author's observations and discussions with key staff from these countries.

England: Service innovation using big data

Councils in England faced severe budget constraints in recent years as a consequence of austerity measures adopted by the Cameron government in response to the global financial crisis. In 2013, further changes were made to the National Health Service (NHS) which had a dramatic effect on the role of councils. The introduction of Health and Social Care Act (2012) saw the transfer of primary care activities (such as population health planning) from the National Health Service (NHS) to local governments. Primary Care Trusts (PCT), which were part of the NHS since 1974, were dissolved and much of their responsibilities in health promotion and disease screening and prevention were transferred to local governments. In addition, Clinical Commissioning Groups (CCG) were established between local government and the NHS in order to commission, or to contract evidence based services that address the population health needs of communities.

At the same time, a new agency, Public Health England (PHE) was established in order to gather data and evidence for CCG and to work with local governments address health inequalities – in essence, health promotion and addressing the social determinants of health. In order to identify and priorities the population health needs of communities, local governments and CCG were required to produce Joint Strategic Needs Assessments (JSNA)[2], using data from PHE and other sources.

The JSNA is driven by the local area health and wellbeing boards, consisting of representatives from local government, the local clinical commission group, the NHS and consumers. The JSNA is essentially a 10 year strategic population health plan for a local catchment area, analogous to the municipal health and wellbeing plans required by the Victorian councils. The relationships between various agencies responsible for health and wellbeing in England are best explained below.



[2] See http://www.lewishamjsna.org.uk/

As a result of the changes in the delivery of primary care services and programs such as cancer screening, child protection, healthy eating and housing access, it has become necessary for local governments to collaborate with other government agencies. Local councils in England are now playing an increasingly pivotal role as coordinators and points of referral to and from other agencies. While these changes were dramatic and were not without controversy, such a severe cuts to council funding by the national government, it did result in some positive outcomes.

One of the most profound changes is the way in which data is collected, analysed and used – one of the main functions of Public Health England. PHE employs researchers, statisticians and public health professionals to gather data from a variety of sources from accident and emergency departments in hospitals through to council services in order analyse and segment data into meaningful sets. These datasets are then provided to councils, which can be at ward levels, so that a range of social issues can be identified. Examples of such datasets may include rate of teenage pregnancies, excessive drug and alcohol consumption and access to fresh fruit and vegetables.

Armed with these datasets, councils can provide targeted and localised interventions aimed at addressing specific issues. Moreover, English councils are now actively addressing social disadvantage and starting to embed a "health in all policies" approach. This is evidenced in the explicit recognition of the four arms of public health in all councils' Joint Strategic Health Assessments.

1. Addressing the wider (social) determinants of health such as housing and employment;
2. Targeted health improvement initiatives such as tacking obesity and promoting healthy eating;
3. Active health protection measures such as monitoring immunisation rates; and
4. Public health care initiatives such as sexual and reproductive health and diabetes self care.

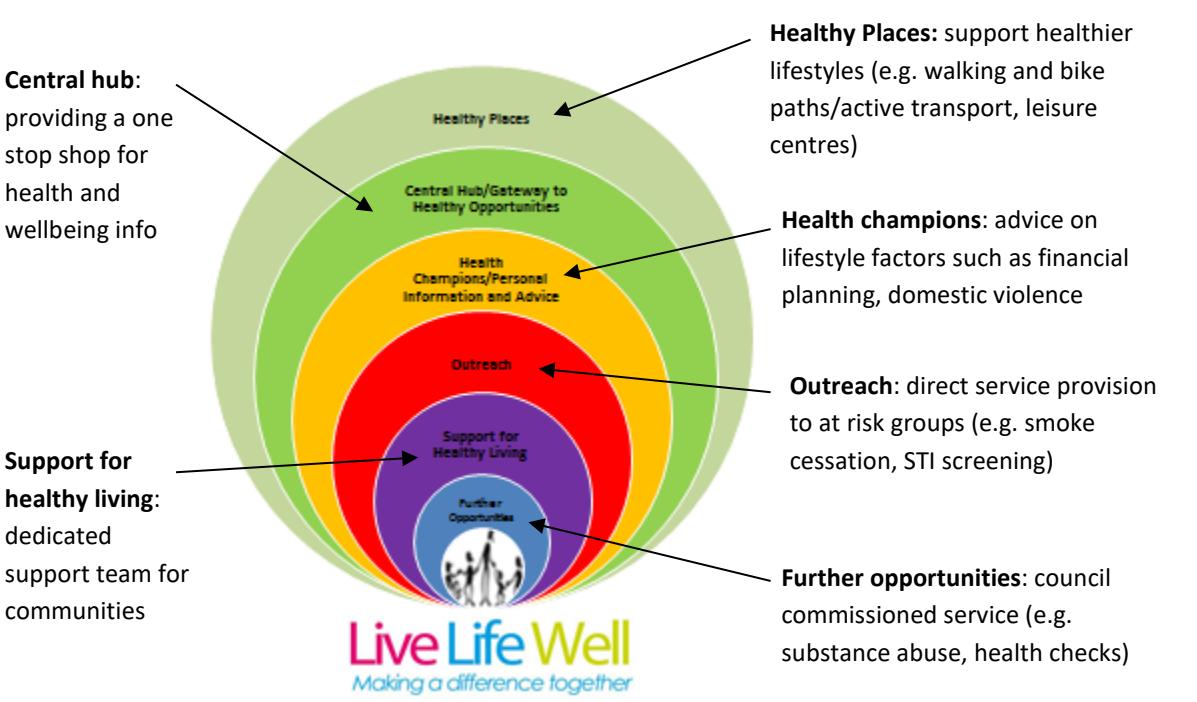
One example of how English councils are utilising data for localised interventions is Sunderland's Live Life Well model.

Case study 1: Using data to generate action

Sunderland is a city in north east of England with a population of 276,000. It is a city facing a number of socio-economic disadvantages and associated poor health outcomes. Adult life expectancy is 9.5 years and 7.1 years below the national average for males and females respectively. The Sunderland Health and Lifestyle Survey found that 62% of the population had at least two unhealthy behaviours (such excessive alcohol intake) and 24% of the population had three or more unhealthy behaviours.

Faced with these enormous changelings, the City of Sunderland decided to tackle health inequalities on an "industrial scale", targeting people with multiple health risk factors. Using data from the Health and Lifestyle Survey, which as broken down to postcode areas, 10 focus groups were held with "at risk" groups and 2 focus groups of residents who made life style changes to address their risk factors. Findings from these focus groups were used to develop the Sunderland integrated wellness delivery model, called Live Life Well, as part of Sunderland's Joint Strategic Needs Assessment.

The model has six aspects, addressing personal and societal factors influencing people's health and wellbeing (i.e. the social determinants of health), as shown overpage.



While the model is currently in operation, the council plans to continually refine the model and its programs by engaging local residents and as more up to date data become available[3].

As the model demonstrates, embedding a social determinant of health approach involves not only accurate and localised data; it also requires placing residents at the centre of programs and interventions. Moreover, such an approach will necessitate the outreaching of services and programs to at risk communities, as opposed to expecting them to access services that are placed there by councils.

Another key feature of take a social determinant of health approach is the need to consider non-health factors and agencies and take a whole of government approach in tackling social inequalities.

These key features require long term political commitment and financial certainty – something that the Scandinavian countries are renowned for.

[3] See http://www.sunderland.gov.uk/index.aspx?articleid=6789

Scandinavia: political commitment to improve health outcomes by addressing social inequalities

The Scandinavian countries are well known for their cohesive societies and general high standards of living. People in countries such as Denmark and Sweden are consistently rated as "happiest", according to the Organisation for Economic Cooperation and Development (OECD) Better Life Index[4], which ranked them 7.5 and 7.2 out of 10 respectively. Australia came in the middle at 7.3. The Better Life Index consists of eleven categories, covering a range of issues such as housing, income, health, life satisfaction and work life balance. Each category is further broken down to a series of indicators such as social inequality and gender inequality, as well as category specific indicators such as life expectancy under the "health" category. What is evident when comparing Australia with Denmark and Sweden is that while Australia performs as well as, or in some cases, better than Scandinavian countries in indicators such as personal income and net household income; we lag behind when it comes to social equality measures.

Such gaps in social equality measures between Australia and Denmark and Sweden are not by accident. All levels of governments in Denmark and Sweden, which have national, regional and local governments similar to Australia, have made explicit commitments to address social inequality, regardless of their political persuasions. For example, the Swedish national government set out a National Public Health Policy based on the social determinants of health model (as opposed to a disease based model) as far back as 2003, when the model is still very much in its infancy. The policy specifically aimed to create societal conditions for good health on equal terms for the entire population and contained eleven objectives split into two broad domains

Structural determinants domain:

- Participation and influence in society
- Economic and social security
- Secure and favourable conditions in childhood and adolescence
- Healthier working life
- Healthy and safe environments and products
- Health and medical services that more actively promotes good health

And life style related domain:

- Effective protection against communicable diseases
- Safe sexuality and good reproductive health
- Increased physical activity
- Good eating habits and safe food
- Reduced use of tobacco and alcohol, a society free from illicit drugs and doping and a reduction in the harmful effects of excessive gambling.

[4] See http://www.oecdbetterlifeindex.org/#/11111111111

In addition, the policy required a national report care every four years, including reporting on quality of life measures, by the national public health agency[5].

As a result of such political commitments, local government authorities are empowered play significant roles in addressing social disadvantage. In contrast to Australian councils, local governments in Denmark and Sweden run a range of health, social and welfare services, in parallel to their regional and national governments. Examples of such interventions can include subsidised child care (approximately A$250 per month) and extended support from child and maternal health nurse to new and at-risk parents. In order to avoid duplication of services between their three tiers of government, there is close collaboration between agencies. Broadly speaking, the national government takes on a whole of government policy approach on major issues such as education, unemployment and the welfare system. Regional governments follow up with regional based health and population planning and some service delivery. Importantly, regional governments provide localised health and social datasets to local governments in order for the latter to provide localised interventions addressing social disadvantage.

One example of the way in which national policy in addressing social inequalities is shaping regional development and planning can be found in the Skåne region of Sweden.

Case study 2: The Open Skåne 2030[6]

Skåne is a region on southernmost part of Sweden with over 1.25 million inhabitants and covering 11,034 square kilometres of land (Victoria covers 237,629 square kilometres and has a population of 5.8 million). It has growing economy and growing population. However, it has also been described as a region of contradictions. While the educational attainment level is relatively high, the portion of youths not completing secondary education is increasing. Similarly, while the region is considered to be multicultural and the demand for labour is high, the employment participation among migrant communities is relatively low.

In response, the regional government initiated the Skåne Dialogue. Over a period of 18 months between 2013 and 2014, the government conducted 35 workshops with over 1,300 participants, there were also focus groups and discussions with secondary schools students. In total, over 4,000 residents were consulted (0.32% of the entire population). In addition, government agencies and departments such as health and medical services, regional development and planning, transport, culture and inter-regional government cooperation were also consulted and took part in the dialogue.

The result is a comprehensive regional development strategy titled The Open Skåne 2030. The strategy contained five key goals

1. Skåne shall offer optimism and quality of life
2. Skåne shall be a strong sustainable growth engine
3. Skåne shall benefit from its polycentric urban structure
4. Skåne shall develop the welfare services of tomorrow

[5] Presentation and personal correspondence with Prof. Bo Burstrom: Centre for Epidemiology and Community Medicine, Karolinska Institutet

[6] See http://cyberaccess.se/clients/langeleve/rus/english-short-version/

5. Skåne shall be globally attractive

The vision for Skåne in 2030 focuses on improving health and wellbeing, reducing health and social inequalities and increasing citizens' trust and participation in the democratic process. It also set indicators for educational attainment, life expectancy, environmental sustainability and employment rate.

Prior to and as part of Open Skåne 2030, the regional government undertook a series surveys from 2000 through to 2013. All parents with children aged between 8 months and 4 years between 2012 and 2013 were surveyed focusing on physical, social, psychological, environmental and economic factors. All children aged 12, 16 and 18 in 2013 were also surveyed to measure social determinant factors such as wellbeing, relationships, physical activities, eating, mental health, tobacco, drugs and alcohol. Finally, 50,000 residents aged between 18 and 80 were selected randomly every four years between 2000 and 2012 asking about their health status and social determinant of health factors.

Armed with data from these surveys, the regional government is now playing an active role in addressing the social determinants of health by:

1. actively supporting municipal governments including conducting health impact assessments on municipal comprehensive plans (similar to council strategic plans;
2. strengthen its public health network by including health and health equity factors in its regional strategy;
3. training politicians in the concept of "public health is politics"; and
4. providing a series of formal and informal networks for municipal governments to exchange ideas and share skills, knowledge and experiences.

It can be seen above that strong commitments from national and regional governments can establish the political framework for action in improving the social determinants of health of their citizens by addressing the underlying social and health inequalities. But how are these actions translated at a local level? For that, we need to examine the city of Helsingborg.

Case study 3: City of Helsingborg[7]

The city of Helsingborg lie in the south western tip of Sweden, in the region Skåne. It is strategically located as a port city across a narrow strait of water between Sweden and Denmark. The city was founded in 1085 and one of its early notable citizens is industrialist Johan Dunker, who established a rubber factory in 1891 and became a generous philantropist. The city hall was opened in 1897 and Sweden´s first city theatre opened in Helsingborg in 1921.

The city currently has 136,500 inhabitants with a population growth of 1,700 per year. Drawing on data from the Skåne adult survey (50,000 respondents) in 2012, the municipal government in 2014 determined to focus on social sustainability as an overarching aim for the city's development. Four priority areas of action are currently underway: homelessness, early intervention (for social issues such as drug and alcohol), education and technological development. Moreover, these priority

[7] Presentation and personal correspondence with Maria Norberg and Kerstin Magnusson, City of Helsingborg

action areas did not just involve local government, but had buy in from other sectors such as academia and educational institutions, which provided evidence based knowledge for application by decision makers. More importantly, these action areas do not operate in silos, but in a cross-sectoral collaborative manner. This "health in all policies" approach is the essential feature of the World Health Organisation Healthy Cities concept.

In the area of housing, the local government has committed to build 700 apartments per year in order to address homelessness. In addition, potential clients for these apartments were invited to take part in a process called "expert by experience". These clients were also had their social and physical needs assessed in order to provide targeted interventions throughout the process. The city officials also took a value-based perspective when interacting with clients, which took a support and understanding approach, rather than a crime and punishment approach.

The city is also undertaking an experimental project developing motivational apps for residents to download on their smart phones. This development involved local educational institutions and also drew on evidence of human psychology on motivation and behavior modification. It is hope that these apps will improve the overall health status of the population through early identification and intervention of at risk health factors.

Once again, explicit recognition and commitment in addressing the underlying social inequalities drive a whole of government approach in the design, implementation and evaluation of programs and initiatives, and the long term effects of such commitment are evident.

Partnerships: the importance of external stakeholder collaboration

Strong political will and commitment in addressing social determinants of health have many positive downstream effects, particularly in planned city and infrastructure development. Cohesive and cooperation between all three levels of government in countries such as Sweden and Denmark are producing positive and sustainable outcomes for communities.

Of equal importance is the collaboration with external stakeholders. This is evident in the work done in Denmark to promote cycling as a mode of transport, while also producing positive health and environmental outcomes.

Case study 4: Cycling in Denmark[8]

Denmark, and particularly Copenhagen, is renowned for its bike culture. However, this bike culture did not occur by accident. A national bike strategy was launched in 2014 by the Ministry of Transport, committing almost A$91 million in improving cycling infrastructure projects, including cycle superhighways, state and local road upgrades and research into bike accidents. In addition, the city of Copenhagen has a 14 year bike strategy (2011-2025), which replaced its former bike policy of 2002-2012. The current bike strategy sets out a number of targets such as the number of bike trips (from 150,000 in 2008 to 240,000 in 2025) and percentage of travels undertaken by bikes (from 36% in 2008 to 50% in 2015).

As part of these ambitious targets, the city of Copenhagen worked closely with other stakeholder such as the Cycling Embassy of Denmark as part of the implementation process. The city planners and economists also collaborated to produce sophisticated socio-economic modeling of the financial impact of cycling. According to the City of Copenhagen Technical and Environmental Administration, each kilometer travelled by bike in Copenhagen has an equivalent societal benefit (economic, health and other benefits) of approximately 30 cents Australian. Similarly, for each kilometer travelled by car that has been transferred to by bike, the societal benefit is calculated to be approximately 40 cents Australian. It is estimated that an A$1 million bicycle bridge would have paid of itself off in 7 years through such savings. It is also estimated that cycling can bring about 30% reduction in mortality for adults who to work daily.

While “Copenhagen” style separate bike lanes are a recent phenomenon in Melbourne, they are the norm in all major cities in Denmark. Further, public transport operators are actively encouraging mix mode transport by offering bike friendly options. Aside from mass undercover bike parking (as opposed to car parking) in major city train stations in Copenhagen, the S-Tog commuter trains introduced bike friendly carriages in 2012 (see photos). These carriages have fold up seats whereby the support structure of the seats double as bike racks. These are used by cyclist to store the bikes during the journey but also allow seats to be folded down for commuter to sit. Data showed that there has been an 8% rise in commuter patronage since their introduction as people started to mix their mode of transport.

[8] Presentation and personal correspondence with Klaus Bonham, Danish Cyclists’ Federation

Singapore: Making health prevention a priority

So far, we have seen the efforts of English councils in using localised and aggregated population data sets to help to plan social interventions to address health inequalities in communities. We also witnessed the effects of long term political and financial commitment in Scandinavian countries and their impact on service provision across the lifespan, built environment and, ultimately, economic and health benefits for their citizens. We now examine how direct government interventions are focusing on health prevention measures to improve the health outcomes of citizens.

Singapore has a well developed economy and is considered a centre for trade, investment and finance in south east Asia. However, its population is also experiencing lifestyle diseases such as hypertension, obesity and increased incidence of type II diabetes similar to many other developed and developing nations around the world.

According to the Health Promotion Board of Singapore, physical inactivity accounted for around 5% of the total burden of disease, or 20,000 Disability Adjusted Life Years (DALY) in 2010; obesity is estimated to be around 10% of the total Singaporean population, an increase of 60% over a 6 year period between 2004 and 2010. Faced with these startling statistics, the Health Promotion Board has proposed a bold two pronged approached consisting of a 5 year physical activity strategy and a 5 year food strategy. These two strategies were approved in late 2015 and work in tandem with each other with the aim of creating a deficit of 200 calories per person per day (the average daily calorie intake for women is between 1,800 and 2,350, and for men is 2,400 and 3,000).

The 200 calorie deficit is made up of 100 calories in extra energy expenditure through the physical activity strategy and 100 calorie intake reduction through the food strategy. Specific actions to be undertaken under the physical activity strategy include:

1. Targeting children and youth by
    a. Increase opportunities for physical activity for children and youth. This includes fun challenges such as “Walking to Bangkok” and “10 Minute Shake Up” in conjunction with commercial/industry partners.
    b. Promoting active recreation by collaborating with the National Parks Board and run cross training program run by Health Ambassadors. This represents a win-win scenario whereby Health Ambassadors conduct nature walks while receiving park guider training, thus increasing the work capacity for national parks.
    c. “Gamification” of health. This includes running Korean pop dance competitions with reward points and behavioural change apps for smart phones.
2. Targeting adults by
    a. Education programs to improve health literacy.
    b. Offering general fitness assessments for adults aged 50 and above and offer customised exercise programs such as Tai Chi and yoga.
    c. Population wide programs such as recruiting residents to the Million Kilo Challenge.
    d. Focusing on at risk communities by offering tailored programs such as Aerobics@Mosque and Soccer@Mosque

On the other hand, the food strategy focused on the following:

1. Reducing consumption of sugar sweetened drinks by increasing availability of low sugar and water products in the retail and food and beverage sectors and in vending machines.
2. Increasing availability of healthier meals when eating out (60% of Singaporeans eat out at least once a day) by
    a. Aiming to have 20% of all meals converted to healthier options.
    b. Working with food vendors to promote lower-calorie meals (e.g. through substitution of healthier oils).
    c. Working with commercial retailers and support early adopters.
3. Increasing availability of health grocery products by
    a. Increasing the sales of whole grains, fruits and vegetables by helping manufacturers to overcome barriers (e.g. working with Department of Trade and Commerce towards food labeling standards).
4. Sustaining demand for healthier food products by
    a. Public education campaign
    b. Use of reward schemes (e.g. extra loyalty points for fruit and vegetable purchases)[9].

It is worthwhile noting that the physical activities strategy and the food strategy contain a number of notable features of the social determinants of health approach:

1. Using a 5 year timeframe for both strategies in order to reflect the urgency of the situation.
2. Setting realistic targets using available data and their associated economic impact/loss.
3. Taking a prevention/primary care intervention approach.
4. Working in collaboration with other government agencies and departments
5. Working with private and commercial sectors in implantation of key programs.
6. Delivering outreach targeted programs to at risk communities.
7. Mixing traditional and innovative program delivery methods.

While it is acknowledged that Australia is already piloting or implanting many of the initiatives outlined in the Health Promotion Board's two strategies, there does seem to be lack of coordinated and whole of government approach in addressing the social determinants of health for the entire population.

[9] Presentation and personal correspondence with Gary Khoo, *Health Promotion Board* of *Singapore*

Conclusion and recommendations

Councils play a vital role in addressing the social determinants of health at local levels. However, they cannot do it alone. Coordinated and whole of government measures are most effective when governments at all levels recognise the impact of the social determinants of health on their citizens. There must also be explicit commitment and associated long term financial investments in addressing inequalities, which in turn, improve the health outcomes for all citizens.

While Victoria leads the way in which it is addressing such social determinants through various programs and agencies, more can be done by closer collaboration with local councils as partners in the design, implementation and evaluation of health promotion and prevention programs. In order to achieve this, the author makes the following three recommendations:

1. That the Public Health and Wellbeing Act (2008) be reviewed, and where possible, amended in order to reflect the role of both the State and local governments in addressing the social determinants of health for citizens. This will bring about closer working relationships between these two levels of government. Specifically, sections 24 through to 27 of the Act outline the requirement for councils to develop municipal health and wellbeing plans and to have regard to the state health and wellbeing plan in the process. By referencing the need for both the State and municipal health and wellbeing plans to embed or have explicit recognition of addressing social inequalities will be a starting point for both levels of government.
2. Establishment of inter-government Public Health and Wellbeing boards to bring about closer working relationships. Members of these boards should be skills based and independently operated in order to hold councils and other government agencies such as the Department of Health and Human Services (DHHS) to account. These boards can be loosely based on the Health and Wellbeing Boards in England, and drive the joint development of both the state and the municipal health and wellbeing plans to ensure greater integration and enhanced level of collaboration.
3. Establish mechanisms for greater opportunities for secondment of staff between councils and other government agencies such as DHHS and the Victorian Health Promotion Foundation (Vic Health). This will not only improve the understanding of operations of councils and key government agencies, but will improve communication between key stakeholders in their common objectives of reducing social inequalities in the community.

Ultimately, all levels of government in Australia must commit politically and financially to reducing social inequalities. While recent government policies and initiatives such as the National Disability Insurance Scheme (NDIS) represent a way forward in empowering people with disabilities to seek out personalised care and improve social integration, there still seem to be a lack of explicit recognition and commitment of addressing social inequalities by our federal government, with possible exception of initiatives such as Close the Gap, which achieved mixed results. While local government at often at the forefront of program development and delivery in addressing the social determinants of health of their residents, greater commitment and cooperation from the State and Federal governments will achieve greater and more sustainable outcomes for communities.

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