

**Homelessness,  
Poverty and  
Discrimination:  
Improving Public  
Health by Realising  
Human Rights**

**Submission to the  
Department of Human Services  
Review of the *Health Act 1958***

**November 2004**

# **Homelessness, Poverty and Discrimination: Improving Public Health by Realising Human Rights**

## **Submission to the Department of Human Services Review of the *Health Act 1958***

Philip Lynch  
Coordinator  
PILCH Homeless Persons' Legal Clinic  
Level 1, 550 Lonsdale Street  
Melbourne VIC 3000  
P: (03) 9225 6684  
F: (03) 9225 6686  
E: [projects.pilch@vicbar.com.au](mailto:projects.pilch@vicbar.com.au)

Deb Tsorbaris  
Chief Executive Officer  
Council to Homeless Persons  
34 Brunswick Street  
Fitzroy VIC 3065  
P: (03) 9419 8699  
F: (03) 9419 7445  
E: [deb@chp.org.au](mailto:deb@chp.org.au)

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## 1. Executive Summary and Recommendations

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### 1.1 Summary

This submission is made jointly by the PILCH Homeless Persons' Legal Clinic and the Council to Homeless Persons to the Department of Human Services Review of the *Health Act 1958* ('the Act').

The submission examines and discusses the relationship between homelessness, poverty, discrimination and public health. The submission also examines and discusses the importance of analysing and addressing these issues in a human rights framework, consistently with Victoria's obligations under the *International Covenant on Economic, Social and Cultural Rights*, to which Australia is a party.

A summary of findings and recommendations is set out below.

### 1.2 Findings

- On any given night, over 20 000 people experience homelessness in Victoria and almost 100 000 people experience homelessness across Australia.
- There are at least 1 million people across Australia living in poverty. In Victoria, it is conservatively estimated that approximately 16 per cent of the population live in poverty.
- Discrimination on the ground of poverty and homelessness, including in the provision of or access to health and medical services, is widespread across Australia and Victoria, and remains lawful.
- There are clear causal and consequential links between homelessness, poverty and poor public health outcomes. Ill health can cause, contribute to and exacerbate homelessness and poverty, and homelessness and poverty can cause, contribute to and exacerbate ill health. There are also clear correlates between discrimination against people experiencing homelessness or poverty and poor health outcomes.
- Under international human rights law, particularly article 12 of the *International Covenant on Economic, Social and Cultural Rights*, all people have the right to the highest attainable standard of health. This right imposes an obligation on governments to establish conditions, including through the adoption of legislative measures, designed to ensure that people have the best possible chance of being healthy. These conditions include that people are able to access the full variety of facilities, goods, services and conditions necessary to ensure an individual's health, including access to appropriate health care, safe water, adequate sanitation, an adequate supply of safe food, adequate nutrition, adequate housing, occupational health, a healthy environment and access to health-related information.
- There is a strong correlation between a state's respect for human rights and that state's success in addressing poverty and promoting public health.

- The promotion of public health requires that factors underlying poor health outcomes, including homelessness, poverty and discrimination, be identified and addressed through a range of legislative and institutional measures. The international human rights framework provides a useful and important framework to identify, monitor, assess and address such factors. Poverty and vulnerability to ill health can be significantly reduced by governmental implementation of obligations to respect, protect and fulfil human rights.

### 1.3 Recommendations

#### ***Scope and Objects of the new Act***

The scope and objects of the new Act should include to:

- Respect, protect and fulfil the human right to the highest attainable standard of physical and mental health;
- Assist to respect, protect and fulfil the human rights necessary for full realisation of the right to the highest attainable standard of physical and mental health, including the right to freedom from discrimination, the right to adequate housing, the right to an adequate income or social security, the right to an adequate standard of living, the right to education, the right to privacy, the right to participation and the right to dignity and respect;
- Assist to identify and address civil, political, economic, social and cultural factors that contribute to health inequalities and ill health, including poverty and discrimination;
- Promote and protect public health and assist to prevent disease, illness, injury, disability and premature death; and
- Provide evidence-based information to the public about public health.

#### ***Guiding Principles***

The new Act should contain Guiding Principles for any decision or order made under the Act. The Guiding Principles should include the following:

- Principle of realisation of human rights which recognises that respect for human rights promotes public health and requires that any decision or order be consistent with human rights norms;
- Principle of non-discrimination, which requires that, with the exception of 'special measures' designed to address disadvantage, discrimination on any ground (including, in particular, the ground of social or socio-economic status) be prohibited;
- Principle recognising that socio-economic status is a critical determinant of health status; that civil, political, economic, social and cultural factors, including poverty and discrimination, contribute to health inequalities and ill health. Further, that any decision or order consider and address these factors;

- Principle recognising that social and economic disadvantage can impair access to health services or programs, and that public health policies and programs should be developed in such a way as to ensure appropriate access for people experiencing such disadvantage; and
- Principle of participation requiring that persons affected or likely to be affected by a decision or order be consulted and provided the opportunity to participate in the decision-making process. Special measures may be required to ensure that impediments to participation, including homelessness, poverty and illiteracy, are identified and addressed as part of the consultation process.

### ***Responsibility for Implementation of the new Act***

The new Act should clearly recognise that ultimate responsibility for public health lies with the federal and state governments. Where the Victorian Government has delegated responsibility for some aspect of implementation of the right to the highest attainable standard of health, the Act should clearly articulate the nature and extent of this delegation.

The new Act should provide effective remedies, enforceable against the Victorian Government, where the implementation of a responsibility under the Act has been insufficient or inadequate.

### ***Functions of the Secretary***

The new Act should provide that the Secretary to the Department of Human Services, in a representative capacity, has primary responsibility for administering the Act.

The Secretary's functions and powers should be set out under the Act and should be to implement policies and programs in accordance with the Guiding Principles of the Act in order to achieve the objects of the Act.

The Secretary should not have the power to conduct inquiries into matters of public health. This power should be delegated to an independent statutory Commissioner for Public Health, established and appointed under the Act.

### ***Partnerships in Public Health***

The new Act should recognise the importance of addressing socio-economic determinants of health, such as homelessness, poverty and discrimination, as part of any public health strategy.

The Act should also promote cooperative research, analysis, and program design and implementation between the health sector and sectors involved in programs relating to human rights that bear on the right to health, such as the right to freedom from discrimination (eg, the Equal Opportunity Commission), the right to adequate housing (eg, the Office of Housing), the right to an adequate income or social security (eg, Centrelink), the right to education (eg, the Department of Education), the right to

privacy (eg, the Privacy Commissioner), the right to participation, and the right to dignity and respect.

### ***Social Health Officers***

The new Act should require that municipal councils appoint a Social Health Officer ('SHO') and that the powers of the SHO include:

- Monitoring and assessing social and economic determinants of health; and
- Providing assistance and advice on social and economic aspects of public health to the Secretary and the council.

### ***Commissioner for Public Health***

The new Act should provide for the establishment of an independent statutory body, the Commissioner for Public Health, with the power to:

- Initiate and undertake investigations and inquiries regarding matters of public health and the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled;
- Receive and consider complaints regarding matters of public health, including in relation to the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled;
- Make determinations regarding matters of public health, including the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled; and
- Make and enforce such orders as are necessary to improve or enhance public health, including by increasing the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled.

Other functions of the body should include:

- Educating the community about matters of public health, including the right to the highest attainable standard of health and social and economic determinants of health, such as homelessness, poverty and discrimination; and
- Advising governments about matters of public health, including the right to the highest attainable standard of health and social and economic determinants of health, such as homelessness, poverty and discrimination.

### ***Health Information***

The information-gathering provisions of the new Act should provide that the Secretary should collect, analyse, disseminate and utilise information about:

- Social and economic determinants of health;
- The relationship between financial and social disadvantage and health;

- The relationship between discrimination and health;
- Systemic health disparities between social and economic groups and the causes of such disparities;
- Allocation of health care resources as between social and economic groups;
- Access to health care, including obstacles and barriers to accessing health care, for people experiencing financial or social disadvantage; and
- The relationship between public health and human rights, including the right to adequate housing, the right to an adequate income or social security, the right to equality and freedom from discrimination, the right to privacy, the right to participation, the right to education, and the right to dignity and respect.

### ***Consultative Council on Social Health***

Recognising the strong correlates between public health and social and economic well-being, the Clinic and CHP also consider that the new Act should establish a Consultative Council on Social Health.

The functions of the Consultative Council on Social Health should include:

- To consider, investigate, monitor, analyse and report on the social and economic determinants of health, including poverty, homelessness and discrimination;
- To consider, investigate, monitor, analyse and report on programs directed towards improvement of the social and economic determinants of health, including programs directed to addressing poverty, homelessness and discrimination;
- To enhance programs directed towards improvement of the social and economic determinants of health by publication and dissemination of information and practical strategies identified by the Council;
- To regularly report to the Minister for Health;
- To respond to matters referred by the Minister to the Council for investigation and reporting; and
- To produce an annual report on the work and deliberations of the Council and make recommendations for systemic change required to improve social and economic determinants of health and address issues of homelessness, poverty and discrimination.

The Consultative Council on Social Health should be conferred with the information-gathering powers necessary to discharge its functions, including a requirement that Social Health Officers report annually to the Council on social and economic factors contributing to ill health and programs directed towards addressing such factors.

### ***Health Impact Assessments***

The new Act should contain provision for the implementation of Health Impact Assessments ('HIAs'). HIAs could play an important role in improving public health and promoting human rights by institutionalising the systematic and routine application of public health perspectives to both the health and non-health sectors. HIAs would provide an important tool pursuant to which the public health impacts of projects, programs and policies in both health and non-health areas, including housing, employment, education, income support and so on, could be identified, analysed and assessed.

### ***Anti-Poverty Strategy and Unit***

Recognising the very strong correlation between poverty and ill health on the one hand, and the alleviation of poverty, investment in targeted health care for the poor and improved public health on the other hand, the Victorian Government should develop a comprehensive anti-poverty strategy that involves:

- Holding an initial summit of state and local governments, the welfare sector, unions, the business sector, community groups, income support customers and relevant experts in the field to highlight the importance of the issue and agree on a timetable for action;
- A commitment to achieve a whole of government approach. That is, coordinated action across policy areas such as employment, health, education, income support, community services, housing and other relevant areas to reduce poverty and poverty of opportunity; and
- A period of consultation not longer than 12 months.

A statutory authority or unit reporting directly to the Premier should be established with responsibility for developing, implementing and monitoring a national anti-poverty strategy. This entity should:

- Establish benchmarks and targets to measure progress against a series of anti-poverty objectives;
- Report regularly to the Parliament on progress against the strategy; and
- Undertake or commission research into a range of poverty-reduction measures.

### ***Homelessness and Health Action Plan***

The Victorian Government should develop a comprehensive homelessness and health action plan. This plan should establish coordinated programs, set timelines and guarantee expenditure to improve public health by addressing and ending homelessness. Under the plan, the Victorian Government should substantially increase funding to improve the availability and accessibility of targeted, specialist health care services for people experiencing homelessness.

### ***Adequate and Effective Protection from Discrimination***

Recognising the strong links between discrimination against people experiencing homelessness or poverty and ill health, the Victorian Parliament should amend section 6 of the *Equal Opportunity Act 1995* (Vic) to include 'social status' as an attribute on the basis of which discrimination is prohibited. Under section 4 of the *Equal Opportunity Act*, 'social status' should be defined to include a person's status as:

- Homeless;
- Unemployed; or
- A recipient of social security payments.

### ***Guaranteed Adequate Income***

An adequate income is a necessary prerequisite to good health. Recognising this, the Victorian Government should lobby the Federal Government to ensure that:

- Social security payments are available to all people who experience a loss of income beyond their control or who require income support to ensure realisation of their human right to an adequate standard of living;
- Social security payments are increased to levels above the Henderson Poverty Line so that recipients are able to meet their material needs and participate in society. Payments should be sufficient to ensure that recipients can afford adequate housing and an adequate standard of living;
- The breach penalty regime under the *Social Security Act 1991* (Cth) is amended so that people are only penalised if they wilfully and intentionally breach their mutual obligations. Penalties should be no longer than 8 weeks duration, no greater than 25 per cent of income and recoverable on compliance or reasonable steps;
- Centrelink's 'proof of identity' requirements are changed so that homeless people can use a letter from a homelessness assistance service as proof of identity; and
- The Australian and Victorian Governments develop an integrated package of social security assistance to homeless people that includes access to health care, adequate housing, employment assistance and personal support to ensure sustainable outcomes.

## **2. Introduction**

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### **2.1 Overview of Submission**

This submission is made jointly by the PILCH Homeless Persons' Legal Clinic and the Council to Homeless Persons to the Department of Human Services Review of the *Health Act 1958*.

The PILCH Homeless Persons' Legal Clinic and the Council to Homeless Persons would appreciate the opportunity to supplement this submission with oral evidence at any public hearing.

This submission examines and discusses the relationship between homelessness, poverty, discrimination and public health. The submission also examines and discusses the importance of analysing and addressing these issues in a human rights framework, consistently with Victoria's obligations under the *International Covenant on Economic, Social and Cultural Rights*.

The submission concludes that Victoria's legislative and institutional frameworks for public health should enshrine the right to the highest attainable standard of health and recognise and respond to the social and economic determinants of health, with particular regard for the special needs of people experiencing financial and social disadvantage, by respecting, protecting and fulfilling human rights.

### **2.2 PILCH Homeless Persons' Legal Clinic**

The PILCH Homeless Persons' Legal Clinic provides free legal services at 9 drop-in centres to people who are homeless or at risk of homelessness. It also undertakes significant community education, public policy advocacy and law reform work. Since its establishment in 2001, the Clinic has provided legal advice to almost 1500 homeless people across Victoria.

### **2.3 Council to Homeless Persons**

The Council to Homeless Persons is a peak body representing homeless persons' agencies in Victoria. CHP's members are service providers that deal directly with people who are homeless. This includes large organisations like the The Salvation Army, St Vincent de Paul, Hanover Welfare Services, Catholic Social Services and Jesuit Social Services, as well as many smaller community-based agencies. CHP's members provide a range of services for single people, families and young people who are homeless. The role of CHP is to represent the views of these agencies and advocate on behalf of homeless people about issues of homelessness. This involves policy analysis and research aiming to ensure that effective strategies to alleviate and end homelessness are developed and implemented.

### **3. Homelessness, Poverty and Public Health**

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#### **3.1 Introduction**

Homelessness and poverty are among the most serious socio-economic and health issues confronting Australia and Victoria.

There are strong associations between homelessness, poverty and poor public health outcomes. There are also clear correlates between discrimination against people experiencing homelessness or poverty and poor health outcomes.

#### **3.2 Homelessness in Victoria**

On any given night, over 20 000 people experience homelessness in Victoria and almost 100 000 people experience homelessness across Australia. This includes over 14 000 people sleeping rough or in squats, more than 14 000 in crisis accommodation or refuges, almost 23 000 in boarding houses, and nearly 49 000 people staying temporarily with friends or relatives. A further 23 000 people across Australia live temporarily in caravan parks.<sup>1</sup> Every day, more than 500 people are turned away from homelessness assistance services due to lack of capacity.<sup>2</sup>

The causes of homelessness are complex and varied. However, they are generally acknowledged to include:

- structural causes (such as poverty, unemployment and inadequate supply of affordable housing);<sup>3</sup>
- fiscal, social and public policy causes (such as taxation policy and expenditure on public and community housing, health care, education and vocational training);
- individual causes (such as ill health, mental illness, intellectual disability, substance and alcohol dependency, problem gambling, domestic violence, family fragmentation and severe social dysfunction); and
- cultural causes (such as the provision of culturally inappropriate housing or support services to indigenous communities).<sup>4</sup>

In many cases of homelessness, these causes are intersectional and related.

In addition to those experiencing homelessness, it is estimated that up to 35 per cent of low income people experience 'housing stress', meaning that their housing costs are so great relative to their income as to jeopardise their ability to meet other basic

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<sup>1</sup> Australian Bureau of Statistics, *Counting the Homeless 2001* (2003).

<sup>2</sup> Australian Institute of Health and Welfare, *Demand for SAAP Assistance by Homeless People 2001-02* (2003).

<sup>3</sup> Following the 2001 Census, the Australian Bureau of Statistics identified unemployment and inadequate income as significant structural factors contributing to and causing homelessness across Australia: Australian Bureau of Statistics, *Counting the Homeless 2001* (2003).

<sup>4</sup> See generally, 'The Changing Face and Causes of Homelessness: Symposium' (2002) 15(9) *Parity*.

needs. Almost 10 per cent of low income people experience 'extreme housing stress', meaning that they are required to spend more than 50 per cent of their income on rent to avoid homelessness.<sup>5</sup>

### **3.3 Poverty in Victoria**

Current levels of poverty in Australia and Victoria are similarly unacceptable.

According to a March 2004 Senate report on poverty and financial hardship, there are at least 1 million people across Australia living in poverty, although most indicators and studies suggest that this number is more likely between 2 and 3.5 million people.<sup>6</sup> In Victoria, it is generally accepted that approximately 16 per cent of the population live in poverty.<sup>7</sup>

A significant contributor to people either living in or being at risk of poverty is that, across Australia, there is no guaranteed minimum income and social security payments are pegged well below the Henderson Poverty Line. According to the Australian Council of Social Service, in September 2002, the base rate of Newstart for a single unemployed adult person was paid at 63 per cent of the Henderson Poverty Line, rising to 78 per cent if the person also received the highest payable rate of rent assistance. For an unemployed young person living independently, the highest rate of payment, including rent assistance, amounts to 67 per cent of the Poverty Line. At the highest end, for a single person with a disability, the base rate of Disability Support Pension was paid at 89 per cent of the Henderson Poverty Line, rising to 108 per cent if the person was also paid rent assistance at the highest rate.<sup>8</sup>

### **3.4 The Relationship between Homelessness and Public Health**

There are strong associations between homelessness and ill health.

Ill health is both a cause and consequence of homelessness.<sup>9</sup> For example, Ill health can cause homelessness by reducing a person's capacity to obtain or maintain an adequate income.<sup>10</sup> Similarly, mental health problems can cause family fragmentation and loss of the social and economic supports necessary to maintain stable housing. Identified health-related consequences of homelessness include low

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<sup>5</sup> Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 123-4.

<sup>6</sup> Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) xv-xvi.

<sup>7</sup> Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 43.

<sup>8</sup> Australian Council of Social Service, *Fairness and Flexibility* (2003) 41.

<sup>9</sup> Adrienne Lucy, 'South Eastern Sydney Area Health Service Homelessness Health Strategic Plan 2004-09' (2004) 17(8) *Parity* 6.

<sup>10</sup> Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 173.

self-esteem, social isolation and mental health problems.<sup>11</sup> In addition, homeless people experience significantly higher rates of death, disability and chronic illness than the general population but have less access to health services.<sup>12</sup>

According to recent studies, homeless people experience significantly higher rates of death, disability and chronic illness than the general population.<sup>13</sup> Identified chronic health issues for people experiencing homelessness include blood borne viruses (particularly Hepatitis B and C), skin infections, cardiovascular disease, depression, post-traumatic stress disorder, malnutrition, dental decay and tooth loss.<sup>14</sup>

Notwithstanding the particular vulnerability of people experiencing homelessness to ill health, homeless people have significantly less access to health services than the broader population.<sup>15</sup> The Senate inquiry into poverty and financial hardship found that homeless people 'miss out on a range of health services'.<sup>16</sup> As one formerly homeless person reports:

I was assaulted several years ago while having no fixed address. I was admitted to the Accident and Emergency department of a major hospital bruised and battered and with two sprained ankles. There was no avenue for effective after care. Who has ever heard of a hospital admission for sprained ankles! For somebody with a safe and secure home, limited use of both legs can be a major inconvenience. For somebody who has no secure home, limited use of their legs can be a serious threat to their continued well-being.<sup>17</sup>

Lack of access to appropriate and affordable health care is often exacerbated by reluctance on the part of many homeless people to engage with services due to previous negative experiences.<sup>18</sup>

Research and experience demonstrate that improving health outcomes for homeless people requires specifically targeted health care services, delivered together with

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<sup>11</sup> Adrienne Lucy, 'South Eastern Sydney Area Health Service Homelessness Health Strategic Plan 2004-09' (2004) 17(8) *Parity* 6, 7.

<sup>12</sup> E Harris, P Sainsbury and D Nutbeam (eds), *Perspectives on Health Inequity* (2000).

<sup>13</sup> E Harris, P Sainsbury and D Nutbeam (eds), *Perspectives on Health Inequity* (2000); Adrienne Lucy, 'South Eastern Sydney Area Health Service Homelessness Health Strategic Plan 2004-09' (2004) 17(8) *Parity* 6, 7.

<sup>14</sup> Adrienne Lucy, 'South Eastern Sydney Area Health Service Homelessness Health Strategic Plan 2004-09' (2004) 17(8) *Parity* 6, 7. See also Royal District Nursing Service Homeless Persons Program, *A Framework: Improving Health Outcomes for People Experiencing Homelessness in Victoria* (1999), cited in Department of Human Services, Victoria, *Primary and Acute Health Responses to People Who Are Homeless or at Risk of Homelessness: Information Paper* (2000) 4; Sam Lees, 'Homelessness Health Issues' (2004) 17(8) *Parity* 30, 30.

<sup>15</sup> E Harris, P Sainsbury and D Nutbeam (eds), *Perspectives on Health Inequity* (2000).

<sup>16</sup> Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 174.

<sup>17</sup> Matt Gleeson, 'Obstacles to Surviving Homelessness' (2000) 13(10) *Parity* 7, 7.

<sup>18</sup> Royal District Nursing Service Homeless Persons Program, *It Can Be Done: Health Care for People who are Homeless* (1992), cited in Department of Human Services Department of Human Services, Victoria, *Primary and Acute Health Responses to People Who Are Homeless or at Risk of Homelessness: Information Paper* (2000) 3.

programs to address underlying causes of homelessness.<sup>19</sup> Despite this, neither Australia nor Victoria has a homelessness action plan, a homelessness health strategy, or adequately funded and appropriately targeted health care services for homeless people.

### 3.5 The Relationship between Poverty and Public Health

There are similarly strong links between poverty and ill health. Socio-economic status is a critical determinant of health status, with lower socio-economic status generally associated with poorer overall health.<sup>20</sup>

Poor health plays a central role in creating, exacerbating and perpetuating poverty. Evidence tendered to the Senate inquiry into poverty and financial hardship demonstrated that poor health can cause poverty (by, for example, reducing a person's capacity to engage in employment or education) and maintain poverty (by, for example, requiring a family to sacrifice basic needs to meet health care costs).<sup>21</sup> As one witness to the Senate inquiry testified:

I have got no health care for my children. I dread every sniffle and cough because I cannot afford to go to the doctor and, if I do go to the doctor, I cannot afford to pay for the prescriptions that they are going to need when I am finished. We may be at the top end of the poverty scale but we are on the downward slide and, if something is not fixed, then that is where we will end up.<sup>22</sup>

Similarly, poverty tends to have a very negative overall impact on public health. Substantial statistical analysis demonstrates that the most critical determinants of a population's life expectancy, a key indicator of public health, are public expenditure on health care and the success of poverty alleviation strategies, including targeted health care programs for the disadvantaged and social security and safety net arrangements.<sup>23</sup> Despite this, neither Australia nor Victoria has an anti-poverty strategy or a targeted and comprehensive health care program for people experiencing poverty. Further, there is no national or statewide program to ensure the conditions necessary for health, including access to adequate housing, nutrition, income support and health and medical services.

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<sup>19</sup> Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 540.

<sup>20</sup> Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 173. See generally Chris Reynolds, *Public Health Law in Australia* (1995).

<sup>21</sup> Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 173.

<sup>22</sup> Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 174.

<sup>23</sup> Sudhir Anand and Martin Ravallion, 'Human Development in Poor Countries: On the Role of Private Incomes and Public Services' (1993) *Journal of Economic Perspectives* 7; Amartya Sen, *Development as Freedom* (1999) 44-7.

### 3.6 Links between Discrimination Against People Experiencing Homelessness or Poverty and Public Health

There are strong links between discrimination against people experiencing homelessness or poverty and the health status of those groups. According to the World Health Organization:

The fundamental principles of equality and freedom from discrimination have been identified as key components in all matters concerning health. This includes non-discrimination in access to health facilities, goods and services, paying particular attention to the most vulnerable or marginalised sections of the population.<sup>24</sup>

The World Health Organization considers that 'discrimination violates one of the fundamental principles of human rights and often lies at the root of poor health status'.<sup>25</sup> This view is consistent with an emerging consensus that discrimination and stigmatization are major causal factors of ill health, including higher anxiety, depression, worsened quality of life, a sense of loss of control and difficulty coping.<sup>26</sup> As St Mary's House of Welcome, a drop-in centre in Fitzroy, Victoria for people experiencing homelessness identifies:

Our service users include homeless people, people in financial crisis, people who are suffering hardship, people with alcohol, drug and gambling addictions, mentally ill people and others of low social status. They experience discrimination because of their social status, their appearance and their lack of access to amenities and services. The effect of this discrimination can be detrimental to health and well-being, result in further financial hardship, and impact negatively on ability to cope.<sup>27</sup>

Discrimination can exclude people from access to good and services, health care, adequate housing, education and employment, all of which are powerful influences on and determinants of public health.<sup>28</sup> Discrimination can also increase vulnerability to or magnify poverty, leading to ill health.<sup>29</sup> Indeed, according to Jesuit Social Services:

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<sup>24</sup> World Health Organization, *Health and Freedom from Discrimination: WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance* (2001) 12.

<sup>25</sup> World Health Organization, *Health and Freedom from Discrimination: WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance* (2001) 6.

<sup>26</sup> Lisa Waller, 'Living with Hepatitis C: From Self-Loathing to Advocacy' (2004) 180 *Medical Journal of Australia* 293; S Zickmund, E Y Ho, M Masuda et al, 'They Treated Me Like a Leper: Stigmatization and the Quality of Life of Patients with Hepatitis C' (2003) 18 *Journal of General International Medicine* 835.

<sup>27</sup> Letter from St Mary's House of Welcome to the PILCH Homeless Persons' Legal Clinic dated 20 August 2002.

<sup>28</sup> Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 539.

<sup>29</sup> World Health Organization, *Health and Freedom from Discrimination: WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance* (2001) 6, 10.

Discrimination, especially in the areas of private housing, room and caravan rental, and also in health, is both widespread and can result in significant psychological deterioration as well as material deprivation of the recipient. Indeed, consistent discrimination of this nature results in deepening of identification with the marginalised condition so as to make negotiation through their issues more difficult.<sup>30</sup>

Despite the clear correlates between discrimination, poverty and public health outcomes, discrimination against people experiencing homelessness or poverty, including in the provision of health and medical services, is not only widespread in Victoria and at a national level, it remains lawful.<sup>31</sup> At a state level, the *Equal Opportunity Act 1995* (Vic) does not prohibit discrimination on the ground of social status, homelessness, poverty, unemployment or on the basis that a person is a recipient of social security or welfare assistance. This lack of legal protection from discrimination causes and contributes to homelessness, poverty and poor public health outcomes.

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<sup>30</sup> Letter from Jesuit Social Services to PILCH Homeless Persons' Legal Clinic dated 22 August 2002.

<sup>31</sup> Philip Lynch and Bella Stagoll, 'Promoting Equality: Homelessness and Discrimination' (2002) 7 *Deakin Law Review* 295.

## 4. Public Health and Human Rights

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### 4.1 Introduction

To effectively promote public health, and address the particular public health needs of those facing homelessness and poverty, issues of homelessness, poverty and discrimination should be contextualised and addressed by reference to the international human rights framework. There is a strong positive correlation between a state's respect for human rights and that state's success in addressing poverty and promoting public health.<sup>32</sup> The *International Covenant on Economic, Social and Cultural Rights* is particularly pertinent to this discussion given that Australia's ratification of this instrument results in tangible legal obligations on the part of both the Commonwealth and the states with respect to human rights, particularly social and economic rights that impact on health.

### 4.2 The Right to the Highest Attainable Standard of Health

Pursuant to article 12 of the *International Covenant on Economic, Social and Cultural Rights*, all people have the right to the highest attainable standard of physical and mental health.<sup>33</sup>

#### ***Content of the Right to the Highest Attainable Standard of Health***

Although the right to health does not necessarily translate as a right to 'be healthy' (the United Nations Committee on Economic, Social and Cultural Rights acknowledges that health is relative to an individual's biological conditions and a state's available resources),<sup>34</sup> the right does impose important substantive obligations on Australian governments to establish conditions, designed to ensure that people have the best possible chance of being healthy, including through the adoption of legislative measures.

According to the Committee, these conditions should mean that people are able to access the full variety of facilities, goods, services and conditions necessary to ensure an individual's health.<sup>35</sup> This includes access to appropriate health care and also access to safe water, adequate sanitation, an adequate supply of safe food, adequate nutrition, adequate housing, occupational health, a healthy environment

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<sup>32</sup> See generally, Amartya Sen, *Development as Freedom* (1999) 49, 87, 90 and 144.

<sup>33</sup> Opened for signature 16 December 1966, 993 UNTS 2 (entered into force generally 3 January 1976 and for Australia 10 March 1976).

<sup>34</sup> Committee on Economic, Social and Cultural Rights, *CESCR General Comment 14: The Right to the Highest Attainable Standard of Health*, [9], UN Doc E/C.12/2000/4 (2000).

<sup>35</sup> Committee on Economic, Social and Cultural Rights, *CESCR General Comment 14: The Right to the Highest Attainable Standard of Health*, [4], [9], UN Doc E/C.12/2000/4 (2000).

and access to health-related information.<sup>36</sup> Services must be provided in a culturally appropriate<sup>37</sup> and non-discriminatory manner.<sup>38</sup>

### ***Obligations of Implementation in Relation to the Right to the Highest Attainable Standard of Health***

Pursuant to article 2(1) of the *International Covenant on Economic, Social and Cultural Rights*, Australian governments are obliged to take steps, using the maximum available resources, to progressively achieve the full realisation of the right to the highest attainable standard of health. As discussed above, this includes particularly the adoption of legislative measures.

According to the Committee, the steps and measures taken must be 'deliberate', 'concrete' and 'targeted as clearly as possible' towards full realisation of the right to the highest attainable standard of health.<sup>39</sup> Progress towards full realisation of the right is required to be as 'expeditious' and 'effective' as possible and requires that the maximum of available resources be directed towards public health, including by ensuring that the attainment of public health is a fiscal and budgetary priority.<sup>40</sup> Further, even while Australian governments are developing and implementing measures for the full realisation of the highest attainable standard of health, they are under an obligation to ensure that certain 'core minimum standards' are met, including the provision of basic housing, nutrition and health care for marginalised or disadvantaged people.<sup>41</sup>

#### **4.3 The Role of Human Rights in Addressing Poverty and Promoting Public Health**

As discussed above, there is a strong positive correlation between a state's respect for human rights and that state's success in addressing poverty and promoting public health.<sup>42</sup>

The international human rights framework provides a useful and important framework to identify, monitor, assess and address the civil, political, economic, social and cultural determinants of poverty and ill health. Poverty and vulnerability to ill health can be significantly reduced by governmental implementation of obligations to

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<sup>36</sup> Committee on Economic, Social and Cultural Rights, *CESCR General Comment 14: The Right to the Highest Attainable Standard of Health*, [11], UN Doc E/C.12/2000/4 (2000).

<sup>37</sup> Committee on Economic, Social and Cultural Rights, *CESCR General Comment 14: The Right to the Highest Attainable Standard of Health*, [12(c)], [27], [37], UN Doc E/C.12/2000/4 (2000).

<sup>38</sup> Committee on Economic, Social and Cultural Rights, *CESCR General Comment 14: The Right to the Highest Attainable Standard of Health*, [43(a)], UN Doc E/C.12/2000/4 (2000).

<sup>39</sup> Committee on Economic, Social and Cultural Rights, *General Comment 3: The Nature of States Parties' Obligations*, UN Doc HRI/GEN/1/Rev.5 (2001) 18.

<sup>40</sup> Committee on Economic, Social and Cultural Rights, *General Comment 3: The Nature of States Parties' Obligations*, UN Doc HRI/GEN/1/Rev.5 (2001) 18, [9].

<sup>41</sup> Committee on Economic, Social and Cultural Rights, *General Comment 3: The Nature of States Parties' Obligations*, UN Doc HRI/GEN/1/Rev.5 (2001) 18, [10].

<sup>42</sup> See generally, Amartya Sen, *Development as Freedom* (1999) 49, 87, 90 and 144.

respect, protect and fulfil human rights.<sup>43</sup> According to former UN High Commissioner for Human Rights, Mary Robinson:

Respect for human rights, the standards of which are contained in numerous international instruments, is an important tool for protecting health. It is those who are most vulnerable in society — women, children, the poor, persons with disabilities, the internally displaced, migrants and refugees — who are most exposed to the risk factors which cause ill health. Discrimination, inequality, violence and poverty exacerbate their vulnerability.

It is therefore crucial not only to defend the right to health but to ensure that all human rights are respected and that the root economic, social and cultural factors that lead to ill health are addressed.<sup>44</sup>

The international human rights framework also imposes obligations on governments to develop and implement policies that provide all persons with the maximum opportunity to be healthy, including by addressing poverty and homelessness.

The interdependence and indivisibility of the international human rights framework makes it clear that while governments have obligations to respect and protect the right to health — including by preventing, treating and controlling disease and ensuring access to appropriate health care — they also have obligations to ensure the conditions required for fulfilment of public health.<sup>45</sup> This requires that they progressively correct conditions that may impede realisation of the right to health — such as poverty and homelessness — as well as ensure that all people can access the goods and services necessary for good health, including through realisation of the right to adequate housing, the right to an adequate income or social security, the right to equality and freedom from discrimination, the right to privacy, the right to participation, the right to education and the right to dignity and respect.

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<sup>43</sup> World Health Organization, *Health and Freedom from Discrimination: WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance* (2001) 6. See also B Loff, 'Reconciling Rights with Risk' in Australian Institute of Health Law and Ethics, *Public Health Law: New Perspectives* (1998) 139.

<sup>44</sup> Mary Robinson, UN High Commissioner for Human Rights, quoted in World Health Organization, *Health and Freedom from Discrimination: WHO's Contribution to the World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance* (2001) 7.

<sup>45</sup> Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 540.

## 5. Reforming the *Health Act 1958* to Address Poverty and Promote Public Health

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### 5.1 Introduction

Improving public health requires not only improvements in the access that people experiencing homelessness, poverty or other forms of disadvantage have to health care, but that the conditions that cause, contribute to, or maintain homelessness and poverty are identified and addressed and that basic human rights are respected, protected and fulfilled.

### 5.2 Overarching Framework

#### ***Scope and Objects of the new Act***

Given the strong associations and correlates between poverty, homelessness and ill health, Victoria's legislative framework and institutions for public health must focus attention on and contribute to the alleviation of poverty.

Further, given the concomitance of the realisation of human rights with creation of the conditions necessary to ensure that people have the maximum opportunity to be healthy, it is imperative that Victoria's legislative framework and institutions for public health enshrine the right to the highest attainable standard of health and contribute to the realisation of interrelated human rights.

As discussed above at Part 4.2 and further below at Part 5.3, in ratifying the *International Covenant on Economic, Social and Cultural Rights*, Australian governments at a national, state and local level committed to, and became responsible for, the implementation of measures to progressively realise the right to the highest attainable standard of health, including by respecting, protecting and fulfilling related human rights. Victoria's legislative framework and institutions for public health should, at a minimum, be consistent with international human rights standards and commitments.

Having regard to the above, the scope and objects of the new Act should include to:

- Respect, protect and fulfil the human right to the highest attainable standard of physical and mental health;
- Assist to respect, protect and fulfil the human rights necessary for full realisation of the right to the highest attainable standard of physical and mental health, including the right to freedom from discrimination, the right to adequate housing, the right to an adequate income or social security, the right to an adequate standard of living, the right to education, the right to privacy, the right to participation and the right to dignity and respect;
- Assist to identify and address civil, political, economic, social and cultural factors that contribute to health inequalities and ill health, including poverty and discrimination;

- Promote and protect public health and assist to prevent disease, illness, injury, disability and premature death; and
- Provide evidence-based information to the public about public health.

### ***Guiding Principles***

The new Act should contain Guiding Principles for any decision or order made under the Act.

Reflecting the proposed objects of the new Act and the implementation obligations imposed on all levels of government and governmental instrumentalities under international human rights law, particularly the *International Covenant on Economic, Social and Cultural Rights*, these Guiding Principles should include the following:

- Principle of realisation of human rights which recognises that respect for human rights promotes public health and requires that any decision or order be consistent with human rights norms;
- Principle of non-discrimination, which requires that, with the exception of 'special measures' designed to address disadvantage, discrimination on any ground (including, in particular, the ground of social or socio-economic status) be prohibited;<sup>46</sup>
- Principle recognising that socio-economic status is a critical determinant of health status; that civil, political, economic, social and cultural factors, including poverty and discrimination, contribute to health inequalities and ill health. Further, that any decision or order consider and address these factors;<sup>47</sup>
- Principle recognising that social and economic disadvantage can impair access to health services or programs, and that public health policies and programs should be developed in such a way as to ensure appropriate access for people experiencing such disadvantage;<sup>48</sup> and
- Principle of participation requiring that persons affected or likely to be affected by a decision or order be consulted and provided the opportunity to participate in the decision-making process. Special measures may be required to ensure that impediments to participation, including homelessness, poverty and illiteracy, are identified and addressed as part of the consultation process.<sup>49</sup>

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<sup>46</sup> This principle is consistent with the principle of non-discrimination contained in both the *International Covenant on Economic, Social and Cultural Rights* (art 2(2)) and the *International Covenant on Civil and Political Rights* (arts 2(1) and 26).

<sup>47</sup> See generally, Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 541-3.

<sup>48</sup> Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 540. See also L A Aday and R M Andersen, 'Equity of Access to Medical Care: A Conceptual and Empirical Overview' (1981) 19 *Medical Care* 4.

<sup>49</sup> Human Rights Committee, *General Comment 25: Article 25*, UN Doc HRI/GEN/1/Rev.5 (2001) 158.

These Guiding Principles of decision-making should be in addition to the principles identified in the Discussion Paper, including the following:

- Principle of evidence-based decision-making;
- Precautionary principle;
- Principle of accountability;
- Principle recognising the community interest in public health;
- Principle of preventing unnecessary encroachment on individual rights;
- ‘Polluter pays’ principle; and
- Principle recognising that the promotion and protection of public health is a collaborative and intersectoral effort.

### 5.3 Intersectoral Relationships

#### ***Responsibility for Implementation***

The attainment of public health requires extensive cooperation and collaboration between governments, government instrumentalities, the private sector, the community sector and individuals. It is important, however, that recognition of the roles of various stakeholders is accompanied by a clear statement of the responsibilities of those stakeholders.

International human rights law adopts a broad and flexible approach to measures required to be adopted by states in respect of the implementation of human rights, including the right to the highest attainable standard of health, so as to enable the legal and administrative structures of each state, as well as other relevant considerations, to be taken into account.<sup>50</sup> Article 28 of the *International Covenant on Economic, Social and Cultural Rights*, however, makes specific reference to states with federal systems such as Australia, stating that ‘the provisions of the present Covenant shall extend to all parts of federal states without limitations or exceptions’. The effect of this provision is to place primary responsibility with governments to ‘ensure that the rights enumerated in the *ICESCR* are enjoyed throughout Australia’, even where legal or administrative arrangements seek to delegate responsibilities in respect of the implementation of human rights to government instrumentalities, the private sector, the community sector and even to individuals.<sup>51</sup>

It is clear, however, that Australia’s ‘collaborative’ or ‘cooperative’ federal arrangements — whereby federal, state, territory and local governments, together with private and community sector actors, are entangled in complicated ‘webs’ of financial and bureaucratic relations — have resulted in a situation where those entities have agreed to take on many of the obligations that are imposed by human

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<sup>50</sup> Committee on Economic, Social and Cultural Rights, *General Comment 9: The Domestic Application of the Covenant*, UN Doc HRI/GEN/1/Rev.5 (2001) 58, [1].

<sup>51</sup> Dianne Otto and David Wiseman, ‘In Search of “Effective Remedies”’: Applying the International Covenant on Economic, Social and Cultural Rights in Australia’ (2001) 7 *Australian Journal of Human Rights* 5, 22.

rights treaties, especially in the area of economic and social rights. That is, state, territory and local governments and private and community sector entities have entered partnership or agency arrangements that make them accountable for implementing those of Australia's international human rights obligations that fall within the scope of these agreements. These entities have directly assumed many international obligations through these domestic agreements; these are obligations for which they can and should be held accountable under domestic legal and administrative processes. In the specific context of the right to the highest attainable standard of health, the sharing of international responsibilities is made abundantly clear by the role of states and private and community sector entities in enacting legislation that creates the framework for public health and developing and implementing health care programs and policies.

Having regard to the above, as a matter of law and principle, the new Act should clearly recognise that ultimate responsibility for public health lies with the federal and state governments. However, where the Victorian Government has delegated responsibility for some aspect of implementation of the right to the highest attainable standard of health, the Act should clearly articulate the nature and extent of this delegation. This would aim to strengthen an agency's accountability for its decision making with reference to international human rights standards.

The provision of effective remedies is fundamental to the implementation of human rights obligations; those whose rights are violated must have access to a means of remedying or rectifying that violation.<sup>52</sup> Under international human rights law, such remedies may be judicial, administrative or policy-based. Thus, the new Act should provide access to effective remedies where the implementation of a responsibility under the Act has been insufficient or inadequate. Given that the ultimate responsibility for realisation of the right to the highest attainable standard of health lies with government, such remedies should be sought from and enforceable against the Victorian Government which could then, in turn, seek to recover any loss from the relevant entity where it related to a delegated responsibility under the Act.

### ***Functions of the Secretary***

The new Act should provide that the Secretary to the Department of Human Services, in a representative capacity, has primary responsibility for administering the Act.

The Secretary's functions and powers should be set out under the Act and should be to implement policies and programs in accordance with the Guiding Principles of the Act in order to achieve the objects of the Act.

The Secretary should not have the power to conduct inquiries into matters of public health. This power should be delegated to an independent statutory Commissioner for Public Health, established and appointed under the Act. This proposal is discussed further below at Part 5.4.

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<sup>52</sup> See generally, Committee on Economic, Social and Cultural Rights, *General Comment 3: The Nature of States Parties' Obligations*, UN Doc HRI/GEN/1/Rev.5 (2001) 18; Committee on Economic, Social and Cultural Rights, *General Comment 9: The Domestic Application of the Covenant*, UN Doc HRI/GEN/1/Rev.5 (2001) 58.

### ***Partnerships in Public Health***

As discussed above and recognised in the Discussion Paper, the promotion of public health requires that factors contributing to poor health outcomes, including homelessness, poverty, discrimination and inadequate realisation of human rights, be identified and addressed.

Although the health sector itself has limited control over socio-economic determinants of health, public health partnerships to develop and implement strategies that target those determinants have the potential to promote both public health and human rights.

In light of this, the Clinic and CHP consider that the new Act should recognise the importance of addressing socio-economic determinants of health — such as homelessness, poverty and discrimination — as part of any public health strategy.<sup>53</sup>

The Act should also promote cooperative research, analysis, and program design and implementation between the health sector and sectors involved in programs relating to human rights that bear on the right to health, such as the right to freedom from discrimination (eg, the Equal Opportunity Commission), the right to adequate housing (eg, the Office of Housing), the right to an adequate income or social security (eg, Centrelink), the right to education (eg, the Department of Education), the right to privacy (eg, the Privacy Commissioner), the right to participation, and the right to dignity and respect.

### ***Social Health Officers***

The *Health Act 1958* (Vic) currently requires that municipal councils appoint Medical Officers of Health ('MOHs') and Environmental Health Officers ('EHOs') to provide advice and to assist in relation to health matters for both the Secretary and the council. Recognising the important role that these officers have played in the development and delivery of public health programs, particularly at a local level, these functions should be retained in the new Act.

However, given the very strong relationship between social and economic factors and public health, the Clinic considers that the new Act should also require that municipal councils appoint a Social Health Officer ('SHO') and that the powers of the SHO include:

- Monitoring and assessing social and economic determinants of health; and
- Providing assistance and advice on social and economic aspects of public health to the Secretary and the council.

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<sup>53</sup> Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 541.

#### **5.4 Commissioner for Public Health**

Under the current *Health Act 1958* (Vic) there is a clear conflict of interest between the Secretary's primary responsibility for implementing the Act and his or her power to conduct inquiries into matters of public health. This conflict arises because, in many cases, the Secretary will be required to inquire into his or her own policies, programs and procedures.

Furthermore, under the current *Health Act 1958* (Vic), there is no provision for the establishment of an independent investigatory or complaints resolution body in relation to matters of public health.

It is axiomatic to the promotion and protection of public health that the new Act provide for the establishment of an independent statutory body, the Commissioner for Public Health, with the power to:

- Initiate and undertake investigations and inquiries regarding matters of public health and the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled;
- Receive and consider complaints regarding matters of public health, including in relation to the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled;
- Make determinations regarding matters of public health, including the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled; and
- Make and enforce such orders as are necessary to improve or enhance public health, including by increasing the extent to which the right to the highest attainable standard of health is protected, respected and fulfilled.

Other functions of the body should include:

- Educating the community about matters of public health, including the right to the highest attainable standard of health and social and economic determinants of health such as homelessness, poverty and discrimination; and
- Advising governments about matters of public health, including the right to the highest attainable standard of health and social and economic determinants of health such as homelessness, poverty and discrimination.

These proposed powers and functions are substantially similar to those conferred on the New South Wales Community Services Commission in respect of community services, which has recently been amalgamated with the New South Wales Ombudsman.

#### **5.5 Health Information**

The collection and effective dissemination of accurate and extensive public health information is necessary for a range of purposes, including identification of the nature, extent and causes of ill health and the determinants of good health and ill health, the

development and implementation of policies and programs to improve public health, and so on.

Section 9 of the current *Health Act 1958* (Vic) confers broad powers on the Secretary to collect, analyse, disseminate and utilise public health information. The Clinic and CHP support the retention of these powers. However, the new Act should contain provisions which make more explicit the nature of certain forms of information that should be collected and the use that should be made of such information.

Significant research has demonstrated that while most public health efforts are intended to benefit the poor and vulnerable, 'a strategic approach is necessary to overcome the tendency for people experiencing poverty to benefit too little from even the best-intentioned public health programs'.<sup>54</sup> In this respect, the World Health Organization considers that,

at a minimum, this requires ongoing monitoring of social inequalities in health, receipt of health care, health care financing, and allocation of health care resources, with built-in mechanisms for translating findings into actions that fill the gaps.<sup>55</sup>

In relation to the collection, use and dissemination of health information, the World Health Organization recommends that:

Routine assessment of potential health implications for different social groups should become standard practice in the design, implementation and evaluation of all development policies ... Routinely collected data on health, health care and other health determinants that are monitored overall should also be disaggregated into more and less socially advantaged groups by factors such as wealth, gender and race/ethnicity that reflect poverty and social disadvantage.

...

Quantitative data should be routinely supplemented by qualitative information from the poor and disadvantaged and their advocates describing unmet need, perceptions of service quality, and obstacles to receiving recommended services in any sector influencing health.<sup>56</sup>

In light of the above, the Clinic considers that the information-gathering provisions of the new Act should specifically provide that the Secretary should collect, analyse, disseminate and utilise information about:

- Social and economic determinants of health;
- The relationship between financial and social disadvantage and health;

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<sup>54</sup> Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 541; Paula Braveman and E Tarimo, *Screening in Primary Health Care* (1994).

<sup>55</sup> Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 541.

<sup>56</sup> Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 542.

- The relationship between discrimination and health;
- Systemic health disparities between social and economic groups and the causes of such disparities;
- Allocation of health care resources as between social and economic groups;
- Access to health care, including obstacles and barriers to accessing health care, for people experiencing financial or social disadvantage; and
- The relationship between public health and human rights, including the right to adequate housing, the right to an adequate income or social security, the right to equality and freedom from discrimination, the right to privacy, the right to participation, the right to education, and the right to dignity and respect.<sup>57</sup>

### ***Consultative Council on Poverty and Social Health***

The *Health Act 1958* (Vic) provides for the establishment of a number of consultative councils comprising health professionals who are experts in the issues within the council's defined terms of reference. These councils play an important role in the continual evaluation and improvement of health services in Victoria.

The Clinic and CHP support the retention of all existing consultative councils in the new Act.

Recognising the strong correlates between public health and social and economic well-being, the Clinic and CHP also consider that the new Act should establish a Consultative Council on Social Health.

The functions of the Consultative Council on Social Health should include:

- To consider, investigate, monitor, analyse and report on the social and economic determinants of health, including poverty, homelessness and discrimination;
- To consider, investigate, monitor, analyse and report on programs directed towards improvement of the social and economic determinants of health, including programs directed to addressing poverty, homelessness and discrimination;
- To enhance programs directed towards improvement of the social and economic determinants of health by publication and dissemination of information and practical strategies identified by the Council;
- To regularly report to the Minister for Health;
- To respond to matters referred by the Minister to the Council for investigation and reporting; and
- To produce an annual report on the work and deliberations of the Council and make recommendations for systemic change required to improve social and

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<sup>57</sup> See generally Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539.

economic determinants of health and address issues of homelessness, poverty and discrimination.

The Consultative Council on Social Health should be conferred with the information-gathering powers necessary to discharge its functions, including a requirement that Social Health Officers report annually to the Council on the social and economic factors contributing to ill health and the programs directed towards addressing such factors.

## 5.6 Health Impact Assessments

According to the World Health Organization:

Work on poverty, equity, human rights and public health must be integrated as an ongoing priority — rather than an afterthought or token concern — across programs.<sup>58</sup>

Recognising this, the Clinic and CHP support the proposal that the new Act contain provision for the implementation of Health Impact Assessments ('HIAs').

Public health is affected by diverse determinants, including civil, political, social, economic, cultural and environmental factors. Under the current *Health Act 1958* (Vic) and related arrangements, however, the issue of public health is not routinely considered in the development and implementation of projects, programs and policies in many of these areas, despite their significant potential impact on public health. Although public health impacts are routinely considered as a component of environmental impact assessments (EIAs), there is no mechanism for the consideration of the public health impacts of projects, programs or policies that fall outside the EIA framework.

In the view of the Clinic and CHP, HIAs could play an important role in improving public health and promoting human rights by institutionalising the systematic and routine application of public health perspectives to both the health and non-health sectors. HIAs would provide an important tool pursuant to which the public health impacts of projects, programs and policies in both health and non-health areas, including housing, employment, education, income support and so on, could be identified, analysed and assessed.<sup>59</sup>

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<sup>58</sup> Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539, 541.

<sup>59</sup> See generally Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health (2003) 81(7) *Bulletin of the World Health Organization* 539.

## **6. Further Measures to Address Poverty and Promote Public Health**

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### **6.1 Introduction**

As discussed at Part 3 above, there are clear causal and consequential links between homelessness, poverty and poor public health outcomes. There are also clear correlates between discrimination against people experiencing homelessness or poverty and poor health outcomes.

This section examines and discusses strategies to ensure that public health is improved through measures to:

- Reduce poverty;
- Address homelessness;
- Prohibit discrimination on the ground of social or economic status; and
- Guarantee that all people are able to access the income support necessary to secure and sustain an adequate standard of living.

### **6.2 Anti-Poverty Strategy and Unit**

There is a very strong correlation between poverty and ill health on the one hand, and the alleviation of poverty, investment in targeted health care for the poor and improved public health on the other hand.

Despite this, neither Australia nor Victoria has an anti-poverty strategy. There is no national or statewide program to ensure the conditions necessary for public health, including access as of right to adequate housing, nutrition, income support and health care and medical services.

Consistent with the recommendations of the Senate Community Affairs References Committee made pursuant to the inquiry into poverty and financial hardship, the Clinic considers that the Victorian Government should develop a comprehensive anti-poverty strategy that involves:

- Holding an initial summit of state and local governments, the welfare sector, unions, the business sector, community groups, income support customers and relevant experts in the field to highlight the importance of the issue and agree on a timetable for action;
- A commitment to achieve a whole of government approach. That is, coordinated action across policy areas such as employment, health, education, income support, community services, housing and other relevant areas to reduce poverty and poverty of opportunity; and
- A consultation period of not longer than 12 months.<sup>60</sup>

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<sup>60</sup> Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 434 [Recommendation 94].

The Clinic and CHP also consider that a statutory authority or unit reporting directly to the Premier should be established with responsibility for developing, implementing and monitoring a national anti-poverty strategy and that this entity:

- Establish benchmarks and targets to measure progress against a series of anti-poverty objectives;
- Report regularly to the Parliament on progress against the strategy; and
- Undertake or commission research into a range of poverty-reduction measures.<sup>61</sup>

### **6.3 Homelessness and Health Action Plan**

As discussed above at Part 3.4, there are strong links between homelessness and ill health. Ill-health is both a cause and consequence of homelessness.<sup>62</sup> Homeless people experience significantly higher rates of death, disability and chronic illness than the general population but have less access to health services.<sup>63</sup> Research and experience demonstrate that improving health outcomes for homeless people requires specifically targeted health care services, together with programs to address underlying causes of homelessness.<sup>64</sup> Despite this, neither Australia nor Victoria has a homelessness action plan or adequately funded and appropriately targeted health care services for homeless people.

In the view the Clinic and CHP, Victoria should develop a comprehensive homelessness and health action plan. This plan should establish coordinated programs, set timelines and guarantee expenditure to improve public health by addressing and ending homelessness. Under the plan, the Victorian Government should substantially increase funding to improve the availability and accessibility of targeted, specialist health care services for people experiencing homelessness.

### **6.4 Adequate and Effective Protection from Discrimination**

As discussed above at Part 3.6, there are also strong links between discrimination and ill health.<sup>65</sup> Despite this, discrimination against people experiencing homelessness, unemployment or poverty, including in health and medical services, is widespread but lawful in Australia and Victoria. At a state level, for example, the *Equal Opportunity Act 1995 (Vic)* does not prohibit discrimination on the ground of social status, homelessness, poverty, unemployment or on the basis that a person is

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<sup>61</sup> Senate Community Affairs References Committee, *A Hand Up Not a Hand Out: Renewing the Fight Against Poverty* (2004) 434 [Recommendation 95].

<sup>62</sup> Adrienne Lucy, 'South Eastern Sydney Area Health Service Homelessness Health Strategic Plan 2004-09' (2004) 17(8) *Parity* 6.

<sup>63</sup> E Harris, P Sainsbury and D Nutbeam (eds), *Perspectives on Health Inequity* (2000).

<sup>64</sup> Paula Braveman and Sofia Gruskin, 'Poverty, Equity, Human Rights and Health' (2003) 81(7) *Bulletin of the World Health Organization* 539, 540.

<sup>65</sup> Lisa Waller, 'Living with Hepatitis C: From Self-Loathing to Advocacy' (2004) 180 *Medical Journal of Australia* 293.

a recipient of social security or welfare assistance. This lack of legal protection from discrimination causes and contributes to homelessness, poverty and poor public health outcomes.

In the view of the Clinic and CHP, it is imperative that the Victorian Parliament amend section 6 of the *Equal Opportunity Act 1995* (Vic) to include 'social status' as an attribute on the basis of which discrimination is prohibited. Under section 4 of the Act, 'social status' should be defined to include a person's status of being:

- Homeless;
- Unemployed; or
- A recipient of social security payments.

## 6.5 Guaranteed Adequate Income

According to Amartya Sen, Nobel Prize Winner for Economics, 'inadequate income is a strong predisposing condition for an impoverished life'.<sup>66</sup> An adequate income is necessary to ensure an adequate standard of living, facilitate participation in the civil, political, economic, social and cultural aspects of community life, and to facilitate access to the highest attainable standard of health.

Recognising this, the Clinic considers that the Victorian Government should lobby the Federal Government to ensure that:

- Social security payments are available to all people who experience a loss of income beyond their control or who require income support to ensure realisation of their human right to an adequate standard of living;
- Social security payments are increased to levels above the Henderson Poverty Line so that recipients are able to meet their material needs and participate in society. Payments should be sufficient to ensure that recipients can afford adequate housing and an adequate standard of living;
- The breach penalty regime under the *Social Security Act 1991* (Cth) is amended so that people are only penalised if they wilfully and intentionally breach their mutual obligations. Penalties should be no longer than 8 weeks duration, no greater than 25 per cent of income and recoverable on compliance or reasonable steps;
- Centrelink's 'proof of identity' requirements are changed so that homeless people can use a letter from a homelessness assistance service as proof of identity; and
- The Australian and Victorian Governments develop an integrated package of social security assistance to homeless people that includes access to health care, adequate housing, employment assistance and personal support to ensure sustainable outcomes.

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<sup>66</sup> Amartya Sen, *Development as Freedom* (1999) 87.