

## The Australian social inclusion agenda

LAST MONTH we saw the first meeting of the Australia Social Inclusion Board. Members of the Board — Ms Patricia Faulkner, Monsignor David Cappelletti, Ms Elleni Beredede-Samuel, Dr Ngaire Brown, Mr Eddie McGuire, Mr Ahmed Fahour, Professor Fiona Stanley and others — are charged with ensuring that every Australian has the opportunity to be a full participant in the life of the nation.<sup>1</sup> In government terms, this means all Australians have the opportunity to: secure a job; access services; connect with family, friends, work, personal interests and local community; deal with personal crisis; and have their voices heard.<sup>2</sup> Monsignor Cappelletti has defined a socially inclusive society as “one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity”.<sup>3</sup> This issue of the journal explores social inclusion from health care perspectives.

Many of the papers in this issue explore aspects of disability and rehabilitation. Consistent with the International Classification of Functioning, Disability and Health (ICF),<sup>4</sup> these papers acknowledge that anyone can encounter health issues and thereby experience some degree of disability (and the associated social exclusion). The ICF has advanced our understanding that disability may involve the majority of the population, and three papers are consistent with this theme. Graham and Cameron suggest an essential need for more rehabilitation services throughout Australia to assist the four million people in Australia with a disability (*page 392*), Goddard and colleagues focus on the needs of the hidden individuals with intellectual disabilities (*page 405*) and Nepal and colleagues model the economic costs of dementia (*page 479*). These articles announce that policy and planning must respond to the needs of these often forgotten populations if we are aiming for social inclusion.

Importantly, the ICF does not focus only on the medical or biological aspects of disability, but takes social aspects into account. Throughout the world there is growing recognition of the impor-

tance of ensuring rehabilitation results in positive social outcomes. Although the social inclusion agenda appears to have been introduced by the current national government, we have been talking about social integration since the 1990s. At the 1995 World Summit for Social Development in Copenhagen, social integration was included on the agenda as: “The aim of social integration is to create ‘a society for all’, in which every individual, each with rights and responsibilities, has an active role to play”. The World Summit agreed a comprehensive and clearly defined series of actions to achieve social integration — many of which have not been achieved today.

While social integration is important to individuals and their families, the lack of action suggests that it is still not seen to be an important outcome for health system policy and planning efforts. The old management adage that “you can’t manage what you don’t measure” is germane — existing health system performance measures do not adequately address the concept of social integration. For example, in a recent research study we found that only 36% of hospital and community health service chief executive officers in Victoria considered performance indicators related to community integration for their service, and less than 5% were able to benchmark community integration indicators.<sup>5</sup> While it is well accepted that those with greater social networks tend, *inter alia*, to be healthier and have greater labour force participation than do those who are less social, there is a lack of well developed, psychometrically sound measures of social integration. We have only patchy evidence about what enhances social integration and social inclusion and therefore have not been successful in designing health care delivery to embrace best practice.

In this issue, Grenade and Boldy explore social isolation and loneliness among older people (*page 468*) and McCormack outlines an initiative designed to enhance the gerontological competencies of social work students (*page 400*). But

there is a long way to go in fulfilling the promise of the ICF in addressing the social aspects of disability. In health systems the ICF's construct of "participation"<sup>1</sup> is a key variable for research, but, once again, an agreed measure of the participation construct has not been developed. As the ICF becomes increasingly adopted as a framework for policy and service development, there is an urgent need for agreed constructs of participation, social inclusion, and social integration (and I am sure there are others) and psychometrically sound measures of these critical constructs.

Clearly, health care providers are not being held accountable for important social outcomes. It is unlikely that we will ever achieve a sustainable health care system in Australia without a greater whole-of-government focus on defining and measuring social inclusion.

In this section, a number of other papers provide assistance to those designing health care interventions, including the use of vouchers for chronic disease care (*page 451*), pulmonary rehabilitation in patients with COPD (*page 415*), psychosocial care for people with cancer in rural communities (*page 423*), physical activity among community-based clients (*page 439*), the use of respite services by carers (*page 459*), and Gill and colleagues suggest that general practice appears to have targeted health assessments to those older persons at highest risk of adverse health outcomes (*page 488*).

## Planning and development

Much to my surprise, *AHR* has taken a leading role in providing useful papers for health sector

planning and development. In this issue, further contributions in this area are made in relation to health impact assessment (*page 509*), health technology decision making (*page 520*), hospital utilisation (*page 528* and *page 537*), and allied health staffing (*page 548*).

## Also in this issue

Our two content sections on Governance and Models of Care are essential reading as *Australian Health Review* aims to further discussion and debate on these two areas crucial to the future success of the health care system.

**Sandra G Leggat**

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- 1 Prime Minister of Australia and Deputy Prime Minister. Australia Social Inclusion Board. 2008. Available at: [http://www.dpmc.gov.au/social\\_inclusion.cfm](http://www.dpmc.gov.au/social_inclusion.cfm) (accessed Jun 2008).
- 2 Department of Education, Employment and Workplace Relations. Social Inclusion Home. 2008. Available at: <http://www.socialinclusion.gov.au/> (accessed Jun 2008).
- 3 Cappel D. Social inclusion initiative. Social inclusion, participation and empowerment. Address to Australian Council of Social Services National Congress; 28-29 November, 2002; Hobart.
- 4 World Health Organization. International Classification of Functioning, Disability and Health. 2002. Available at: <http://www.who.int/classifications/icf/site/icftemplate.cfm> (accessed Jun 2008).
- 5 Leggat SG, Bartram T, Stanton P. People management in Victorian community health services: an exploratory study. *Aust J Prim Health* 2007; 12: 59-65. □