Funding model and model of care

Windana's position statement

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WINDANA

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Contents

Introduction

Victoria deserves an alcohol and drug (AOD) sector that meets the needs of people with substance use concerns.

However, current funding models and a lack of capacity right across the AOD sector severely limit its ability to meet the increasing complexity and severity of current and future demand for our services.

Windana is calling for structural change to how the AOD sector is funded to reflect the true cost of service delivery. This will ensure the sector's ability to innovate and provide the tailored therapeutic care our State deserves.

A properly funded AOD sector not only benefits those who need support for their substance use concerns, it creates healthier, happier, and more prosperous communities for everyone.

Below is a summary of Windana's positions and recommendations regarding funding and model of care.

Windana's positions and recommendations

Funding model

Funding for, and investment in, AOD treatment services in Victoria must be increased to match the current and future needs and complexity of alcohol and other drug service users. The current base funding model does not meet the cost-of-service delivery

Windana is calling for an urgent review of the current model to reflect the true costs of delivering alcohol and other treatment services, ensuring:

- AOD services are adequately and sustainably funded for the agreed targets in funding agreements.
- The model is built with alcohol and other drug service users at the centre.
- Funding matches the qualified workforce required to meet the current and emerging needs and complexity of AOD service users (see workforce development for more information).
- The model rewards achievement of agreed outcomes and encourages innovation

Access to treatment

Victoria currently has the second lowest number of AOD residential beds per head of population in Australia.

Residential withdrawal and rehabilitation capacity in Victoria needs to be increased to ensure people can get the help they need, when they need it.

- Any increase in residential rehabilitation beds should be matched with an increase in residential withdrawal beds.

- Any new Therapeutic Communities/residential rehabilitation facilities should be established at a scale that ensures they are operationally and financially sustainable. Windana's analysis shows this is a minimum of 45 beds.

Review the current central intake system to create a system that is truly client-centred and trauma informed.

- Increased support (via waitlist management/outreach) for those waiting and/or preparing for residential treatment, addressing the gap created by the end of the state-funded COVID-19 workforce initiative.

Tailored services

Create specifically designed residential and other services for marginalised and/or at-risk groups including LGBTIQ+, Aboriginal and Torres Straight Islanders, CALD, Mother's with babies and/or young children. Windana recommends:

- Ensuring current services are culturally safe and welcoming for everyone, regardless of their background.
- Investigating opportunities to create residential facilities designed for specific at-risk cohorts.

Housing

There needs to be equitable access to social housing for people leaving AOD residential rehabilitation.

Windana recommends:

- Prioritising a portion of social housing from Victoria's Big Build for AOD service users. This should include housing arrangements that are free from alcohol and drug use for people who have completed residential rehabilitation.
- Trialing a Prevention and Recovery Care model for housing for people leaving residential rehabilitation.

Evidence summary

Specific Population AOD Services

Specific populations face specific challenges related to AOD use. People from minority and marginalised groups may be unwilling to seek help and engage with treatment if they feel that they would be placed in an environment where they would continue to be marginalised and unable to safely express their identity. People may feel stigma and shame arising out of both their identity and their substance use, which often leads people to be unwilling to access treatment, especially if they feel that the stigma will be repeated in treatment. Many minority and marginalised groups also experience poverty and disadvantage, which presents another significant barrier in accessing services (RCVMHS 2021, p.10).

Aboriginal and Torres Strait Islander Australians continue to live the effects of colonisation and discriminatory government practices which sought to marginalise them and extinguish their culture (RCVMHS 2021, p. 13). Therefore, services need to ensure that treatment will not be another place where culture is stripped and that the care is informed by the trauma that Aboriginal and Torres Strait Islander people have faced and continue to face in Australia (RCVMHS 2021, p. 69).

Similarly, care needs to be informed by the unique needs that Culturally and Linguistically Diverse and LGBTIQ people face respectively. Services also need to be culturally appropriate for their groups, such as having a workforce which reflects people from diverse backgrounds, multilingual information, understanding and integration of religious and social practices and taking care to not be too 'Anglocentric' and repeat the same process of marginalisation of the outside mainstream society (VAADA 2016, p. 73).

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people in Australia face unique challenges regarding AOD use. Aboriginal and Torres Strait Islander people were more likely to consume alcohol compared to their non-Aboriginal counterparts.

18.7% of Aboriginal and Torres Strait Islander people drank, on average, more than two drinks a day, compared to 15.2% of their non-Aboriginal counterparts (AIHW 2022c).

10.6% of Aboriginal and Torres Strait Islander Australians consumed 11 or more drinks on one occasion at least once a month, almost double than of the 6.4% figure among non-Aboriginal Australians (AIHW 2022c).

However, Aboriginal and Torres Strait Islander Australians are twice as likely to abstain from alcohol than non-Aboriginal Australians (AIHW 2022c). Similarly, Aboriginal and Torres Strait Islander people are 1.4 times more likely to have taken illicit drugs in the past year (AIHW 2022c). Compared to non-Aboriginal Australians, Aboriginal and Torres Strait Islanders are 1.3 times more likely to use cannabis, 2.3 times more likely to use pain killers and opioids non-medically and 2.4 times more likely to use methamphetamine (AIHW 2022c).

Drugs such as MDMA and cocaine are taken by a similar or slightly lower proportion of Aboriginal and Torres Strait Islander Australians as compared to non-Aboriginal Australians (AIHW 2022c). Data from the Alcohol and Other Drug Treatment Services National Minimum Data Set shows that

Indigenous Australians accounted for 17% of all clients of AOD treatment services in 2019–20 (AIHW 2022c).

Many AOD organisations in Victoria offer specialised programs for Aboriginal and Torres Strait Islander clients and residents. Further, several Aboriginal organisations, corporations and cooperatives run AOD treatment services.

According to the Australian Indigenous Health InfoNet Alcohol and other Drugs Knowledge Centre, there are ten 'Indigenous specific' organisations which offer AOD services in Victoria (AOD Knowledge Centre 2022). Most of these are non-residential support programs.

Others, such as the Njernda Aboriginal Corporation, based in the Echuca region, operate Baroona Healing Centre, which is a 12 bed, 16-week residential rehabilitation centre for local Aboriginal youth aged 14-22 (Njernda 2022). It is located on a 320-acre farm and Aboriginal culture, practices and spirituality play a key role in the program's services (Njernda 2022).

Similarly, Bunjilwarra, located in Hastings and operated by the Victorian Aboriginal Health Service and YSAS, is a 12-bed residential rehabilitation facility for Aboriginal youths aged 16-25 (Bunjilwarra 2022). Bunjilwarra states that its 'service model is firmly placed in context of the Aboriginal-defined notion of healing and in a cultural framework, supported by trauma-informed practice' (Bunjilwarra 2022).

Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) people

For LGBTIQ people in Australia, drug and alcohol use is, for the most part, higher than in the general population.

- Recent Cannabis use was reported by 30.4% of the LGBTIQ population, higher than the 10.4% figure in the general population (Hill et al. 2020, p. 65),
- MDMA use in LGBTIQ people is at 13.9% and cocaine use at 9.6%, compared to 2.2% and 2.5% respectively in the general population (Hill et al. 2020, p. 65).
- Alcohol consumption is generally in line with the Australian population, but 25.3% of LGBTIQ respondents reported drinking more than two standard drinks a day, higher than in the general population where the rate is 16.1% (Hill et al. 2020, p. 62).

Results from a survey report from 2020 showed that of the LGBTIQ respondents who have struggled with drug use in the past year:

- only 10.8% reported that they would prefer support from a mainstream service,
- with 34% preferring to seek support from 'a mainstream service that is LGBTIQ inclusive' and
- 22.4% of respondents preferring a service 'that only caters to' LGBTIQ people (Hill et al. 2020, p. 68).

However, it should be noted that 42.7% stated that they did not know or did not have a preference (Hill et al. 2020, p. 68).

Among LGBTIQ youth (aged 14 to 17 years), 47.7% had reported as ever drinking alcohol, lower than in the general population of that age at over 60%, however, LGBTIQ youth aged 18 to 21 are more likely to drink, with 85.8% reporting having ever drinking alcohol (Hill et al. 2021, p. 104; Guerin and White 2020, p. 30). Among LGBTIQ youth aged 14-17, use of cannabis, cocaine and MDMA were broadly the same with their counterparts in the general population (Hill et al. 2021, p. 105; Guerin

and White 2020, p. 74). However, LGBTIQ youth aged 18-21 are more likely to use cannabis than their general population counterparts (36.1% against 25%) more likely to use MDMA (12% against 10.8%) and much more likely to use tranquilizer anxiolytics (7.2% against 2.6%) (Hill et al. 2021, p. 105; AIHW 2022a, S2.52). However, LGBTIQ youth aged 18-21 were less likely to use cocaine (5.8% compared to 10.8%) (AIHW 2022a).

When seeking support for AOD use, many LGBTIQ people have indicated that it is important that services are LGBTIQ inclusive, with some indicating a preference for LGBTIQ only AOD services (Hill et al. 2020, p. 68).

Most AOD services in Australia state that they are LGBTIQ inclusive, but few run specialised programs for LGBTIQ people and even fewer run LGBTIQ exclusive residential rehabilitation centres. While organisations such as Thorne Harbour Health run AOD services exclusively for LGBTIQ people and The Hader Clinic claims to operate LGBTIQ specialised treatment, there is no available evidence that any LGBTIQ exclusive residential rehabilitation centres exist in Australia (The Hader Clinic 2022a).

Such treatment centres seem not to exist outside of major LGBTIQ population centres in America (California, New York, Minneapolis). Pride Institute, located just outside of Minneapolis, USA, is a LGBTIQ exclusive residential rehabilitation centre (Pride Institute 2022). Pride Institute allows residents to stay up to 90 days and claims to offer a nuanced approach which gives a higher level of understanding and support to LGBTIQ people (Pride Institute 2022).

Hazelden Betty Ford, a large American AOD service provider, operates LGBTIQ specialised services and programs in their residential treatment centres in St Paul, Minnesota; Rancho Mirage, California and New York (Hazelden Betty Ford 2022). These LGBTIQ specialised programs include 'LGBT focused small group sessions', 'process support groups that address LGBT community topics and issues' such as discrimination, identity and stigma and dual diagnosis care (Hazelden Betty Ford 2022).

There is little information about LGBTIQ specialised AOD treatment or exclusive rehabilitation centres outside of the USA. StreetScene, a UK AOD service provider, claimed that they had a LGBTIQ specialised unit in their Allington House rehabilitation centre in 2016, but there is no evidence that this still exists (StreetScene 2016).

Culturally and Linguistically Diverse (CALD) populations

Culturally and Linguistically Diverse (CALD) populations in Australia also display different patterns of AOD use than the general population. On average, CALD groups in Australia consume significantly lower amounts of alcohol and use less drugs than those who speak English at home. 3.8% of people who speak a language other than English at home have more than two standard drinks a day compared to 18.8% of those who speak English at home (AIHW 2022b). Similarly, people who speak a language other than English were four times less likely to binge drink monthly compared to English at home speakers.

For drugs, 6.4% of people who speak a language other than English at home have used illicit drugs in the past year, compared to 18.7% of English at home speakers. For specific drugs, people who speak a language other than English at home were 7.6 times less likely to use cocaine, 8.5 times less likely to use methamphetamine, four times less likely to use MDMA and 3.6 times less likely to use cannabis (AIHW 2022b). Despite making up just over a quarter of Victoria's population, only around

5% of closed treatment episodes in Victoria applied to clients born overseas, many of which are from the UK and New Zealand (VAADA 2016, p. 44).

In relation to CALD population groups, there are limited AOD resources available in different languages and delivered in a culturally appropriate way (VAADA 2016). As stated, while CALD groups report using significantly less AOD, and are vastly underrepresented in AOD services, some of this may be due to underreporting by these groups, often caused by cultural, linguistic and structural barriers (VAADA 2016).

One of the few resources on AOD issues in CALD groups in Victoria was developed by VAADA in 2016, and reports that, due to the social and familial structures in many CALD groups, many who have substance use issues do not seek help because substance use is seen as especially shameful, a sign of weakness and damaging family reputation (VAADA 2016, p. 10).

The report also found that current AOD services are seen by some in CALD communities to be culturally inappropriate, too 'Anglocentric' and not catering to their cultural practices and mores, leading them to not seek further help from AOD services (VAADA 2016, p. 73).

Parents and children

Due to the severe effects of AOD use in pregnancy and on the development of young children, mothers are another at risk population group in the AOD sector. The data on women drinking while pregnant is unclear.

The Australian Institute of Health and Welfare's report on the health of mothers and babies, based on data from the National Perinatal Data Collection, indicates that less than 5% of women report drinking during pregnancy, most of which occurred in the first semester (AIHW 2022d).

However, the National Drug Strategy Household Survey states that 35% of Australian mothers drink during pregnancy, 90% of whom drank once a month or less (NDHS 2020, p. 73).

Half of Australian mothers drank some alcohol during breastfeeding (NDHS 2020, p. 73). 5.4% of mothers used cannabis and 1.8% used other illicit drugs before they knew they were pregnant (NDHS 2020, p. 73). Data from 2007 indicates that:

- 13.2% of all Australian children are raised by parents with substance use issues
- 60,000 Australian children had a parent attending drug treatment
- 70% of clients at a Victorian AOD service reported that their children had witnessed and were distressed by their substance use (Rossiter et al. 2013, pp. 6-7).

A handful of organisations in Australia operate AOD rehabilitation facilities which focus on mothers and parents and allow their children to live on site. The Odyssey House Therapeutic Community in Lower Plenty, Victoria, is the only residential treatment program in Victoria that allows parents to have their children aged up to 12 years stay with them while being treated, as to keep the family unit together and drug free (Odyssey House 2022). Children can attend either an on-site child development centre or local kindergartens and primary schools and engage in activities and developmental opportunities. There are currently 30 beds available for children at Odyssey House (Odyssey House 2022).

Kathleen York House in Sydney is a women's-only AOD rehabilitation service run by the Alcohol and Drug Foundation NSW where women, including pregnant women, can live on site with their children

under 11 years of age, many of whom are at risk of being put into care (Kathleen York House 2022; Rossiter et al. 2013, p. 13). Kathleen York House runs a six month residential rehabilitation program and has space for six women and their children, who can attend local schools and kindergartens (Kathleen York House 2022).

Jarrah House in Sydney also allows young children to stay with their mothers while they undergo a ten-week residential rehabilitation treatment (Jarrah House) Cyrenian House in Perth runs the Saranna Women and Children's Program as part of the Rich Hammersley Centre Therapeutic Community which allows women to live with their young dependent children while living onsite, the only such program in WA (Cyrenian House 2022). Families are accommodated in their own individual house on the property, of which there are 13, and, as at Odyssey House, children can attend childcare onsite or in the general community and are offered activities and counselling (Cyrenian House 2022).

Uniting also operates a mother and baby withdrawal service at their Curran Place residential withdrawal facility in Ivanhoe, Victoria (Uniting 2022). It has space for up to four mothers and their babies under 14 months to stay for 7 to 10 days while mothers participate in detox and activities and babies are cared for by specialist staff (Uniting 2022).

Trauma Informed Care

Trauma-informed care is a principle for effective support which is responsive to the impact of trauma (ACI 2022, p. 1). Trauma-informed services seek to not retraumatise or blame those who have experienced trauma for the way they manage their traumatic reactions (NSW Health 2022). Trauma-informed care seeks to create opportunities for people who have experienced trauma to rebuild a sense of control and empowerment in their lives (ACI 2022, p. 1). As such, trauma-informed care is built on the following six principles (NSW Health 2022)

- Safety, physical, psychosocial and emotional for both clients and staff.
- Trust, ensuring that clients can trust the service and that treatment is sensitive to their needs.
- Choice, ensuring that clients are given opportunities to choose.
- Collaboration, ensuring that clients feel they are being worked with instead of just being subjects.
- Empowerment, ensuring that empowerment is a key end goal and focus.
- Respect for diversity, ensuring that diversity is embraced in all its forms.

According to the Agency for Clinical Innovation (ACI 2022, p. 2), in practice, trauma-informed care means:

- Treating clients with empathy and compassion.
- Taking the time to engage with clients to build trust.
- Engaging in dialogue to understand a client's experience.
- Providing clients with access to space, resources or supports.
- Providing choice and collaboration wherever possible.
- Assuming clients are doing the best they can with the resources they have, at all times.

The current international evidence-base for trauma-informed care shows that it is associated with decreased use of seclusion and restraint, shorter lengths of stay, improved symptoms, better

patient-reported outcomes and coping skills, lower staff injuries and cost effectiveness (ACI 2019, p. 8).

The delivery of trauma-informed care as part of the mental health and AOD system's models of care and as part of a new state-wide trauma service is a key recommendation of the Royal Commission into Victoria's Mental Health System (RCVMHS 2021, p. 59).

Access to Housing Post-Treatment

Currently, frequent usage of mental health and AOD services is correlated with housing insecurity (AHURI 2021, p.3). Housing, mental health and AOD sectors are largely separate service systems with little formal integration and coordination. The central argument of much of the 2021 Australian Housing and Urban Research Institute report is that this all needs to be better integrated (AHURI 2021, p.3).

This lack of integration means that there is unmet demand, resulting in higher rates of inpatient care, increased need for AOD services and greater pressure on housing support (AHURI 2021, p.4). Therefore, it is argued that transitional services and supports should be tailored to individual needs in relation to material infrastructures (housing, employment, finances), social infrastructures (community integration and belonging) and affective infrastructures (intimate and social relationships, identity and hopes) (AHURI 2021, p.4).

The Australian Housing and Urban Research Institute report calls for an increase in funding support for the provision of new social housing in order to guarantee access to safe and secure housing for all Australians, especially those at risk coming out of treatment (p.4).

The 2021 Australian Housing and Urban Research Institute report identified the following policy issues for the mental health/AOD sector relating to post-treatment housing (AHURI 2021, p.5).

- Housing affordability
- Social housing shortages
- Lack of supported housing

These are some of the main barriers in achieving housing and housing security for post-treatment individuals and those living with mental health and people who use drugs.

As mentioned previously, these issues mean that there is a significant level of unmet demand for housing support, large resource gaps and there are constraints on achieving coordination between systems. As a result, housing transition supports ought to be integrated more effectively into discharge planning in mental health inpatient care and AOD residential services.

The report argues that the emphasis in mental health and AOD sectors on bureaucratic and administrative processes over an individual's care needs should be reversed, as discharge planning ought to begin from the point of view of the individual in care, calling for a more 'person-centred approach' to care coordination and service delivery (AHURI 2021, p.5).

National and international evidence consistently demonstrates that people exiting institutional spaces, such as AOD residential programs, experience a high risk of housing insecurity post-discharge, which can lead to people re-entering treatment (AHURI 2021, p.9). Hence why there needs to be a smooth transition upon leaving residential care and why knowledge of a person's housing situation and preferences is crucial.

The Australian Housing and Urban Research Institute report gives evidence of the experiences of people exiting treatment into poor and unsuitable housing conditions and situations. People leaving residential AOD treatment may be able to find decent private housing, but if they are living in an area characterised by high drug use or are living with people who are using drugs, then their likelihood of using drugs again is increased. As a result, many people leaving treatment make an effort to find housing away from other people who use drugs, to increase their chances of not having to go through treatment again (Linton et al. 2017).

People who are living with alcohol problems who are in 'housing first' programs accrue, according to a study in Seattle, 53% less costs than those in other types of housing programs, on waiting lists or no stable housing, as well as decreased rates of daily drinking (Larimer et al. 2009). Here, costs meaning the costs of public services such as jails, shelters, hospitals, other medical services, etc. The provision of housing for people with alcohol problems reduces hospital visits, admissions and duration of hospital stay for housing insecure and homeless individuals (Larimer et al. 2009). Trial projects of Housing First models performed in Europe and Australia showed increased retention rates and, in some cases, lower AOD use, but little change overall and in some cases increased engagement with the criminal justice system (ADF 2020, pp. 11-12).

Prevention and Recovery Care Model

Another model of post-treatment/supported housing for people with substance use issues is the Prevention and Recovery Care model, commonly referred to as PARC. Prevention and Recovery Care houses are facilities used by the mental health sector as 'step up step down' facilities, meaning that they are used when a person feels like they are in the early stages of a mental health episode and need more support than they would at home, or that they are for when a person has been discharged from a more acute hospital inpatient settings, but still requires support in a community-based setting to help them integrate back into independent living in the wider community (NWMH 2022). They are classed as a sub-acute mental health service which operates in the community, treating people experiencing a severe and acute mental health episode through clinical and psychosocial support, while also providing opportunities for recreation and wellness activities (DHHS 2016).

Prevention and Recovery Care services are designed to be short-term residential treatment services with a recovery focus on getting people back to independent living. Prevention and Recovery Care services aim to provide a length of stay between one and four weeks, with an average length of stay of 18 days (DHHS 2016, pp.8-9). Residents at Prevention and Recovery Care services are encouraged to leave the site and visit family and friends, while also attending their sessions at the Prevention and Recovery Care service (NWMH 2022).

There are currently 25 Prevention and Recovery Care locations across Victoria, representing 260 beds across the state, as most individual Prevention and Recovery Care services are run on a small scale of around 10 beds (NWMH 2022; DHHS 2016, p. 3). Currently, a new Prevention and Recovery Care location is being built in St Albans which is designed specifically for women and has designated beds for children of the women staying there (VHBA 2022). While currently, few of the clients using Prevention and Recovery Care services have substance use issues, it has been suggested that the Prevention and Recovery Care model could be adopted in the AOD sector as a means of providing supported housing for those coming out of or going into residential services as a 'step up step down' facility.

Funding model

Most of the current funding in the Victorian AOD sector is through the use of Drug Treatment Activity Units - commonly referred to as DTAUs - which allocates funding based on the number of weighted services providers deliver to clients. Activity-based funding is the preferred method of government funding across the health sector and was introduced in the AOD sector in 2014 for non-residential services and in 2019 for residential services.

It replaced the previous Episode of Care funding model which was introduced as part of the AOD sector overhaul in 1997. This model was based off the government purchasing outputs from service providers in the form of a specified number of Episodes of Care in defined service types (Victorian Auditor-General 2011, p. 13). Episode of Care based funding was removed because of concerns that it was creating 'perverse incentives' for service providers to 'prematurely close Episodes of Care either by opting for shorter, fragmented or partial responses to client needs; or by recording multiple continuous Episodes of Care for the same client in the same service type, in order to meet targets and retain funding levels' (Victorian Auditor-General 2011, p. 13).

Despite this, Episode of care funding is still used for state funded youth and Aboriginal specific AOD services (Department of Health 2021, p. 4). Block grant funding is used for activities such as pharmacotherapy, research and drug prevention (Department of Health 2022).

VAADA states that the current Drug Treatment Activity Unit model is inflexible and underestimates the cost of drug treatment activities (VAADA 2022b, p. 31). VAADA claims that the current Drug Treatment Activity Unit model does not properly consider that AOD presentations are encumbered with other issues, meaning that much work and activity goes underfunded. This can include, 'liaising and supporting service users with the NDIS', 'aftercare', 'housing', 'secondary consults' and a whole range of other services (VAADA 2022b, p. 32).

The 2015 Aspex report raised several similar issues with Drug Treatment Activity Unit funding model. There were concerns that the Drug Treatment Activity Units were 'poorly priced', providing insufficient funding to meet the necessary level of service provision (Aspex Consulting 2015, p. 52). Aspex also stated that 'the relativity in pricing of service types … does not appropriately reflect difference in the cost of service delivery' and that Drug Treatment Activity Units create difficulty in managing budgets and staff resources for AOD service providers (Aspex Consulting 2015, p. 52). The Aspex report led to new guidelines being adopted by the Department in September 2018.

The 2016 Larter report set out what it considered to be appropriate funding benchmarks for AOD residential rehabilitation services. It recommended that the funding benchmarks be:

- $224.95 per bed day for residential rehabilitation for the adult population (NADA 2019, p. 9).
- $310.81 per bed day for residential rehabilitation for treating complex needs patients such as dual diagnosis, rural and Aboriginal and Torres Strait Islander residents (NADA 2019, p. 10).
- $613.50 per bed day for inpatient withdrawal management (NADA 2019, p. 10).

Optimal cost models in the Larter report change depending on the number of beds in a service and whether it is for youth or adult residential rehabilitation. While $224.95 per bed day is optimal for an adult residential rehabilitation service with 70 beds, that figure increased to $310.81 for a service with 30 beds and then further to $613.50 per bed day for a service with 15 beds (NADA 2019, p. 9).

For youth residential rehabilitation services, the optimal cost for 12 beds was $675.36 per bed day, increasing to $820.64 per bed day for eight beds (NADA 2019, p.9). It should be noted that these costings were given in 2016, so inflation needs to be considered when reckoning current day operating costs.

Social Determinants of Health

The social determinants of health are the economic and social conditions which people are born, live, work and socialise in that influence different health outcomes (VicHealth 2015, p. 6). It is also a framework that acknowledges the role socioeconomic status has in determining health outcomes (WHO 2010).

Socioeconomic status can be a major determinant of health outcomes, such as rates of diabetes, hypertension and substance use related harms. Socioeconomic status often encompasses various factors such as income, occupation, level of education, living conditions and the level of 'prestige, power, control or social standing' associated with these factors (VicHealth 2015, p. 5). Other social determinants of health can be race, ethnicity, aboriginality, rurality and access to key services (VicHealth 2015, p. 5).

Related to the concept of 'social determinants of health' are the 'social determinants of health inequities', which are the underlying social structures and processes which assigns people to different social positions and unequally distributes the social determinants of health (VicHealth 2015, p. 6). Based primarily on access to money and resources, the social determinants of health inequities determine the level of exposure and vulnerability to conditions which may be detrimental to health outcomes, such as overcrowded housing, sedentary work or access to fresh food (VicHealth 2015, p. 6). This means that efforts to minimise the effects of social determinants on health should address the underlying structures and process of distribution which drive those health inequities if they are to be successful in improving health outcomes (VicHealth 2015, p. 6).

These material and social circumstances can be either detrimental or beneficial to health, with people facing different levels of exposure and vulnerability to poor health conditions based on their social position. For example, even in places where higher socioeconomic groups drink more or the same level of alcohol as those in lower socioeconomic groups, people in lower socioeconomic groups suffered from alcohol related harms and death at a much higher rate than those in high socioeconomic groups (Mäkelä 1999, p. 879).

Stemming out from a person's social position are their daily living conditions, which represent their everyday circumstances and can be determinants of health as well as a setting where action can be taken to address health outcomes (VicHealth 2015, p. 8). This can include early childhood development, education, work and employment, physical environment, social participation and health care services (VicHealth 2015, p. 8).

Further downstream from this is an individual's lifestyle factors and attitude towards health, which is influenced and informed by their social position and daily living conditions (VicHealth 2015, p. 8). This can include whether someone partakes in risky alcohol consumption or substance use, which is generally correlated with lower socioeconomic status (Friel 2009, p. 3).

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