



Public Health Association of Australia:

Policy-at-a-glance – Health Inequities Policy

Key message: PHAA will –

1. Work within the health system, with other health bodies, and organisations in other sectors to build a movement committed to a reduction in health inequities, global trade reform, global economic regulation and health development; and collaborate in advocacy with others to seek commitment from Australian governments to develop a health inequities framework.
2. Advocate for the development of Australian Government policies and programs and evaluation processes to measure progress in line with the:
 - A) World Health Organisation’s Commission on Social Determinants of Health recommendations;
 - B) United Nations Millennium Development Goals;
 - C) Australian Government’s six key targets for Closing the Gap on Indigenous Disadvantage; and
 - D) Australian and jurisdictional governments’ two headline goals articulated in the 2008 national response to homelessness.
3. Advocate for increased research on interventions to reduce health inequities.

Summary: The reduction of social and health inequities should be an overarching goal of national policy and recognised as a key measure of our progress as a society. The Australian Government, in collaboration with the States/Territories, should outline a comprehensive national cross-portfolio and cross-government framework on reducing health inequities. This policy seeks to outline a series of principles and tangible actions designed to achieve these goals.

Audience: Australian, State and Territory Governments, policy makers and program managers.

Responsibility: PHAA’s Political Economy of Health Special Interest Group (SIG).

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HEALTH INEQUITIES POLICY

This policy can be applied across all PHAA policies.

The Public Health Association of Australia notes that:

1. Overall, Australians have high life expectancy. Australians enjoy one of the highest life expectancies in the world, at 81.4 years – second only to Japan (1).
2. However this longevity is not shared equally among Australians. Significant differences remain across a range of health outcomes for different groups of Australians, including rates of death and disease, life expectancy, self perceived health, health behaviours, health risk factors and health service utilisation. These “health inequities” are associated with a range of socio-economic factors including differences in education, occupation, income, employment status, rurality, ethnicity, Aboriginality, gender, housing status and disability (1, 2, 3, 20, 23) (See also PHAA policy on *Gender and Health*).
3. Indigenous people in Australia represent the most significant health inequity compared with the broader community. Indigenous life expectancy is approximately 17 years lower than the non-Indigenous population and Indigenous people have higher rates of death for almost all causes. Indigenous people also bear a greater burden of disability and illness in a range of areas including cardiovascular disease, accidents and injuries, respiratory diseases and diabetes (1, 3, 4, 20).
4. There is a socioeconomic gradient in health. Generally speaking, people in lower socioeconomic groups have shorter life spans and poorer health. They have higher rates of death and disease, are more likely to be hospitalised and are less likely to use specialist and preventative health services. It is not only people in poverty whose health is affected by inequity; the higher a person’s socioeconomic status, the more likely they are to be healthy (1, 2, 21).
5. There are different dimensions of poverty which contribute to poor health. Impoverished people experience multiple forms of deprivation including material deprivation, marginalisation, exclusion, powerlessness and the denial of opportunity and choice. They are significantly less able to participate in society: economically, socially, culturally and politically.
6. Poverty significantly impacts on health outcomes. Homelessness is a significant problem in Australia. According to the Australian Government White Paper on homelessness, in Australia, around 105,000 people are homeless on any given night. Increasing numbers of children, families and older people are experiencing homelessness and Indigenous Australians are also over-represented in the homeless population. International research indicates that people living on the streets suffer from the highest rates of premature death (23, 25).

7. On an average day during 2007-08, an estimated 654 people (436 adults and unaccompanied children and 218 accompanying children) required new and immediate accommodation in Supported Accommodation Assistance Program (SAAP) services. Of these, 269 were able to be accommodated, while 385 people (241 adults and unaccompanied children and 144 accompanying children) were turned away without receiving SAAP accommodation (28).
8. People with mental illness experience poorer health outcomes than the mainstream population (26). Multiple risk factors (e.g. alcohol and drugs, food insecurity) combined with a lack of protective factors (e.g. childhood experiences, income) can predispose a person to the development of mental illness (27). People experiencing mental illness or homelessness also face significant barriers to accessing services which contribute to poor health outcomes (26, 27).
9. The determinants of health inequities are largely outside the health system and relate to the inequitable distribution of social, economic and cultural resources and opportunities. Health inequities are the result of the interaction of a range of factors including: macro politico-economic structures and policy; living and working conditions; cultural, social and community influences; and individual lifestyle factors (5-7, 21, 22, 23). Lifestyle factors are primarily an expression of the structural inequities that underpin them.
10. While conditions experienced during the early years of life have a major impact on health and life chances of individuals, the health impacts of social and economic differences are also cumulative across the life course (5-7, 21).
11. Health inequities are evident both within and between countries. Gross health inequities have been documented between developed, transitional and developing countries across a range of health indicators. For instance, a girl born today can expect to live for more than 80 years if she is born in some countries – but less than 45 years if she is born in others. Within countries there are also dramatic differences in health that are closely linked with degrees of social disadvantage (8-9, 21, 22).
12. There are many reasons to reduce health inequities (10):
 - 12.1 Health inequities are unjust as they are generally not biological, but are determined by factors which are largely outside the control of the individual and are potentially avoidable (a).
 - 12.2 Health inequities are avoidable and amenable to change: shifts in socioeconomic conditions can change the health of populations in the short term both positively and negatively.
 - 12.3 Because of the socioeconomic health gradient, virtually everyone's health can be improved if inequity is reduced.
 - 12.4 Health inequities arguably affect everyone's health and wellbeing. The excessive burden of health and welfare problems such as infectious disease, alcohol and other drug misuse, mental illness, housing insecurity and violence in disadvantaged groups also have adverse health and social impacts on all sectors of society.
 - 12.5 There are major economic impacts of social and health inequities. Excess morbidity and mortality directly attributable to disadvantage is a major economic burden, both in terms of increased health and

social costs and reduced economic productivity. Programs to reduce health inequity can be cost effective and may be promoted on efficiency grounds. Addressing health inequities will also help address the currently increasing burden of chronic lifestyle diseases by assisting in the achievement of key health promotion and preventive health goals.

- 12.6 There is evidence that some relative health inequities may be increasing (1, 2, 3). Overall improvements in population health status may obscure the relative lack of improvement or deterioration in the health of some groups, for instance Aboriginal populations.
13. Increasing inequality in income within society leads to an increase in health inequities (9).
14. Free market economic approaches to health care provision have been shown to widen socio-economic and health inequities. Since free market approaches to health care provision tend to entrench socioeconomic disadvantage and health inequities, we caution against a free market model in health care planning and delivery. There is a place for a limited market approach, or private sector, in health care planning and delivery as long as accountability measures are established by Governments to ensure that there is no increase in inequity, consumer exploitation or rising health care costs, or that such problems can be identified early and addressed (11,12, 24).
15. International trade agreements have been associated with adverse impacts on health, especially of poor people, and the provision of health services. The negative impacts of privatisation of the provision of clinical and public health services are particularly relevant in this context (See PHAA policy on *Trade Agreements in Health*).
16. Health inequities are not currently measured effectively in Australia. Without appropriate measurement and indicators, it is impossible to measure progress towards reducing health inequities across the Australian community.
17. As a consequence of inequity, poorer and more marginalised people will receive greater adverse impacts from climate change because of geography, poorer infrastructure and lower capacity to adapt. Due to their higher risk and vulnerability and lower responsive capacity, these groups will need a greater level of support as part of Australia's response to climate change.

The PHAA affirms the following principles:

18. Access to social, economic and environmental conditions and health services that sustain and promote the highest attainable state of health is a fundamental human right. All Australians should have equal opportunities for health (13, 14).
19. Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate social and health measures (15). Governments should ensure that public health and health care systems do not contribute to health inequities and ultimately work towards reducing them, and that their services are aimed at those with the greatest need. Where they exist, Governments should oversee/guide free market (private sector) approaches,

closely monitoring them to ensure they do not contribute to health inequalities. Governments have a duty to intervene in and regulate markets in the interests of health.

20. Widening social and health inequities are a barrier to Australia's fair and sustainable social, economic and cultural development. Health inequities represent a significant cost to the whole community.
21. Policies and programs to address health inequities should be aimed at achieving equity of health and health outcomes, not only equality of health sector resource distribution (16).
22. Innovative public health policy tackling health inequities addresses, and is best framed around, social determinants of health (17, 18, 21) (b). Interventions to improve health inequities should also take a life course perspective.
23. People and communities having control over their lives is fundamental to good health (see PHAA *Consumer, Community and Public Participation* policy).

The PHAA believes that the following steps should be undertaken:

24. The reduction of social and health inequities should be an overarching goal of national policy and recognised as a key measure of our progress as a society.
25. The Australian government, in collaboration with the states, should outline a comprehensive national cross-portfolio and cross-government framework on reducing health inequities.
26. This policy framework needs to include and coordinate the following policy objectives in line with the above principles:

Reduce poverty and social inequity, including by:

- Addressing social determinants of health, including policy responses in the areas of income, welfare, employment, retirement, education, housing, infrastructure, transport, environmental sustainability, gambling and food insecurity.
- Undertaking health inequality impact assessment of all public policy to assess its ramifications for society as a whole and particular groups with lower health status.
- Addressing the negative impacts of chronic illness and disability on social status.

Ameliorate the adverse effects of social disadvantage on health, including by:

- Investing in strategies and programs to support the early years that increase the life chances of children;
- Working with local communities and governments in disadvantaged regions to increase environmental infrastructure which improves health (eg recreation facilities, safe public transport and streets, civic and community infrastructures such as neighbourhood houses, access to 'vegetable gardens' and community centres and social participation opportunities).

Provide public health and health care services, especially to those most in need and disadvantaged communities, including by:

- Provision of comprehensive Primary Health Care (as described in PHAA *Primary Health Care* policy).
- A high quality, accessible and publicly funded health system including access to essential medicines, dental care and aged care.

This policy framework should be supported by:

- Accurate monitoring of health inequities and the impacts of policy including systematic differences in health determinants. This should be linked to, or incorporated into, the National Health Performance Framework endorsed by the Australian Health Ministers Conference (AHMC).
- Increased research funding to examine the relationship between health inequities and social, economic and cultural opportunities and to research in a systematic way the impact of policies and interventions designed to reduce inequities.

27. All levels of government and civil society engage actively in a process of reconciliation between Aboriginal and Torres Strait Islander peoples and other Australians (c).

The PHAA resolves to undertake the following actions:

28. Work within the health system, with other health bodies, and organisations in other sectors to build a movement committed to a reduction in health inequities, global trade reform, global economic regulation and health development.

29. Collaborate in advocacy with others to seek commitment from Australian governments to develop the health inequities framework described above by:

- engaging high level politicians as champions for reducing health inequities;
- seeking cross party support for a parliamentary committee on reducing health inequities;
- analysing the health inequality impact of the platforms of the major parties in the lead up to elections; and
- promoting public awareness and dialogue on health inequities and appropriate responses to them.

30. Advocate for the development of Australian Government policies and programs and evaluation processes to measure progress in line with the World Health Organisation's Commission on Social Determinants of Health recommendations to:

- improve daily living conditions;
- tackle the inequitable distribution of power, money and resources; and
- measure and understand the problem and assess the impact of action (21).

31. Advocate for the development of Australian Government policies and programs and evaluation processes to measure progress in line with the United Nations Millennium Development Goals to:

- eradicate extreme hunger and poverty;
- achieve universal primary education;
- promote gender equality and empower women;
- reduce child mortality;

- improve maternal health;
- combat HIV/AIDS, malaria and other diseases;
- ensure environmental sustainability; and
- develop a global partnership for development (22).

32. Advocate for the implementation of, and effective evaluation of progress against, the Australian Government's six key targets for Closing the Gap on Indigenous Disadvantage, in order to address social determinants of health, namely to:

- close the life expectancy gap within a generation;
- halve the gap in mortality rates for Indigenous children under five within a decade;
- ensure access to early childhood education for all Indigenous four year olds in remote communities within five years;
- halve the gap in reading, writing and numeracy achievements for children within a decade;
- halve the gap for Indigenous students in year 12 attainment or equivalent attainment rates by 2020; and
- halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade (20).

33. Advocate for the implementation of, and effective evaluation of progress against, the Australian and jurisdictional governments' two headline goals articulated in the 2008 national response to homelessness to:

- halve overall homelessness by 2020; and
- offer supported accommodation to all rough sleepers who need it by 2020 (23).

34. Advocate for increased research on interventions to reduce health inequities through such measures as:

- establishing dedicated research funding and infrastructure;
- calling on the Australian Institute of Health and Welfare and all jurisdictional governments to improve measurement by establishing clear benchmarks to measure systems performance in reducing health inequities;
- encouraging researchers to work in the area of health inequity and submit high quality research proposals;
- identification of public health infrastructure, organisations and systems which could support a rapid cycle of collaborative innovation, monitoring, evaluation and knowledge sharing on health inequity (19); and
- working with and learning from disadvantaged groups where appropriate, notably Aboriginal and Torres Strait Islander peoples.

35. Advocate that research focuses on the following topics:

- using a 'point of influence' model (see point 25 above) to analyse health and other sector policy inputs and impacts (5);
- analysis and development of economic and social policies that reduce health inequities; and
- investigation of how innovative public sector administrative and budgeting structures can contribute to improved intersectoral collaboration (19).

36. Advocate that university public health courses and leadership programs make the study of health inequity and the political economy of health a core part of their curriculum.
37. Endeavour to have the social determinants of health placed on the agenda of other degrees and courses outside the traditional health sphere so students may develop an appreciation of the potential impacts their chosen field has on population health – for instance, town planning , civil engineering, architecture, Master of Business Administration (corporate social responsibility) etc. Such discussions may facilitate intersectoral collaboration to reduce health inequities.

ADOPTED 2001, REVISED AND RE-ENDORSED 2002, 2006 AND 2009

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- (a) The term “health inequities” has been used in this policy, in preference to the more frequently used term “health inequalities”, as it more aptly describes avoidable and unjust health differences (16).
 - (b) For example, the objectives of Sweden’s public health policy include “participation and influence in society”, “economic and social security”, “secure and favourable conditions during childhood and adolescence” and a “healthier working life” (17).
 - (c) This process should involve measures of acknowledgement and reparation, as appropriate and identified by Aboriginal and Torres Strait Islander communities, such as: support of self determinism; economic, social, and political participation; and resolution of key issues such as Native Title and the Stolen Generations.
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