Chapter 2

Evidence for the Social Determinants of Health in Australia

2.1 Even in the world's wealthiest countries there are significant discrepancies in life expectancies and health outcomes between groups in society. Research into the correlation between health outcomes and factors such as education and income has led to a growing understanding of the sensitivity of human health to the social environment. Such factors, which include education, gender, power and the conditions of employment, have become known as the social determinants of health.[1] It is argued in the World Health Organisation's Commission on Social Determinants of Health's (CSDH) report *Closing the Gap in a Generation* (WHO Report), that:

> The structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequalities between and within countries.[2]
>
> …
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> Reducing health inequities is, for the Commission on Social Determinants of Health, an ethical imperative...there is no necessary biological reason why there should be a difference in [life expectancy at birth] of 20 years or more between social groups in any given country. Change the social determinants of health and there will be dramatic improvements in health equity.[3]

2.2 By addressing the social determinants of health that are the genesis of many health problems, the costs to government of providing healthcare can be reduced, and individuals can enjoy better health outcomes. One recent Australian study found that by addressing the social determinants of health in line with the recommendations of the WHO Report (discussed in Chapter 3), then:

- 500 000 Australians could avoid suffering a chronic illness;
- 170 000 extra Australians could enter the workforce, generating $8 billion in extra earnings;
- Annual savings of $4 billion in welfare support payments could be made;

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1 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 7.

2 Commission of the Social Determinants of Health, *Closing the Gap in a Generation: Health equity through action on the social determinants of health*, World Health Organisation, Geneva, 2008, p. 1.

3 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 26.

- 60 000 fewer people would need to be admitted to hospital annually, resulting in savings of $2.3 billion in hospital expenditure;
- 5.5 million fewer Medicare services would be needed each year, resulting in annual savings of $273 million; and
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts would need to be filled each year, resulting in annual savings of $184.5 million each year.[4]

2.3 Social determinants do not attempt to address the choices of specific individuals, but the context in which personal choices are made. The committee heard that:

> Often when people talk about social determinants they are talking about preventative health – stopping people from smoking and having poor diets or getting diabetes or HIV or whatever it happens to be. That is not actually dealing with the social determinants of health. That is an element of an approach and it is a very important element of an approach to dealing with health outcomes and population health, but it is not the whole story.
>
> I think that sometimes we fall into that trap of thinking that, if you deal with prevention and get health promotion right, you solve health outcomes. You do not. But all you are doing is stopping someone from smoking or reducing obesity rates. You are not dealing with income, you are not dealing with educational outcomes, you are not dealing with people's housing situations, which as we know are the key things to sort out. Most of these other health issues are not such an issue in the end anyway. As we all know, there is higher prevalence of these types of diseases, illnesses and conditions in people who have poor housing, low income, poor access to education who are born in particular parts of the country.[5]

2.4 Professor Moore from the Public Health Association of Australia articulated the meaning of 'social determinants':

> Australians ought to get it, because it is just about a fair go; it is just about common sense. Take as an example two people growing up in different communities. One is from the North Shore of Sydney, who has educational opportunities, is encouraged by their parents, has adequate food and has parents who are not alcoholics. Compare that person to the extreme case of somebody growing up in the community of Yuendumu, just out of Alice Springs, where there are not the educational opportunities and encouragement. I have to say they do have a lot of other things like family support and so forth; I am not saying it is all negative. But their health outcomes would be very different.[6]

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4 Catholic Health Australia, *Submission 19*, p. 3.

5 Mr Symondson, Research and Policy Manager, Victorian Healthcare Association, *Committee Hansard*, 4 December 2012, p. 56.

6 Professor Moore, Chief Executive Officer, Public Health Association of Australia, *Committee Hansard*, 12 October 2012, pp. 1–2.

2.5 This chapter provides an overview of the theory and evidence underpinning the argument that social determinants of health are a major health problem that needs to be addressed, with a particular focus on Australia. The following chapter will examine the WHO Report.

The key social determinants of health

2.6 The social determinants of health are interrelated. Although they are considered here in isolation, in any one person's life several may be relevant. For example, a single parent may have limited access to the labour market which may compel the family to live in a poorer neighbourhood, enjoy fewer amenities and medical services, and buy less-nutritious food. It also means that the children may be more likely to do worse at school and later may themselves have more trouble accessing the labour market, in turn resulting in a negative impact on their health.[7]

2.7 The following sections highlight a number of key areas of life and society in which the social determinants of health play out. In particularly, early childhood education, employment and income, and access to healthcare are discussed. These three issues were highlighted to the committee as being among the most important in improving the social determinants of health.[8]

Early life and children

2.8 The foundations of adult health have been shown to be laid before birth and in early childhood. Underlining the inequalities in society that can begin to impact on health from birth, the WHO Report argues:

> Children from disadvantaged backgrounds are more likely to do poorly in school and subsequently, as adults, are more likely to have lower incomes and higher fertility rates and be less empowered to provide good health care, nutrition, and stimulation to their own children, thus contributing to the intergenerational transmission of disadvantage.[9]

2.9 The WHO Report is unequivocal on the importance of Early Childhood Development (ECD):

> The science of ECD shows that brain development is highly sensitive to external influences in early childhood, starting in utero, with lifelong effects. The conditions to which children are exposed, including the quality of relationships and language environment, literally 'sculpt' the developing brain. Raising healthy children means stimulating their physical, language/cognitive, and social/emotional development. Healthy development during the early years provides the essential building blocks

7 HealthWest Partnership, *Submission 16*, pp. 2–3.

8 Mr Laverty, Catholic Health Australia, *Proof Committee Hansard*, 4 December 2013, p. 9; Mr Symondson, Victorian Healthcare Association, *Proof Committee Hansard*, 4 December 2013, p. 59; Professor Baum, Professor of Public Health, *Committee Hansard*, 12 October 2012, pp. 17–18.

9 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 50.

> that enable people to lead a flourishing life in many domains, including social, emotional, cognitive, and physical well-being.[10]

2.10 Deficiencies in foetal development are a risk for health in later life. For example, infants with a birth weight less than 2.5 kilograms have almost seven times the chance of developing diabetes in later life than infants born weighing in excess of 4.3 kilograms.[11] Insecure emotional attachment and poor stimulation as an infant can lead to reduced readiness for school, low educational attainment, problem behaviour, and the risk of social marginalisation in adulthood. Furthermore, the development of good health-related habits such as eating sensibly, exercising and not smoking, is associated with parental and peer group examples, as well as with education.[12]

2.11 Investment in ECD has great potential to reduce health inequalities; furthermore, it is an investment likely to pay for itself many times over according to the WHO Report.[13] There are strong intergenerational effects evident in the health and education outcomes of children. The level of education of the mother has been recognised for the last two decades as a critical determinant of child health and educational attainment.[14]

2.12 Speaking in relation to the social determinants of health in Australia, Catholic Health Australia CEO Martin Laverty cited early childhood experience as one of the 'best building blocks of income and social status', and argued that 'early childhood development is one of the most crucial determinants that governments and civic society organisations can invest in'.[15] Similarly, Professor Fran Baum highlighted for the committee that:

> I think we are still clear that the best investment we can make in terms of social determinants is giving every child a good start to life. Of course, that starts in pregnancy, and there is more and more information that there are a whole lot of things that happen when you are a foetus that affect your chances in life subsequently.[16]

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10 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 50.

11 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, pp. 14–15.

12 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 14.

13 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 51.

14 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 50.

15 Mr Laverty, Chief Executive Officer, Catholic Health Australia, Committee Hansard, 4 December 2012, p. 9.

16 Professor Baum, Professor of Public Health, *Committee Hansard*, 12 October 2012, pp. 17–18.

2.13 In Australia, research has indicated that although all children benefit from early childhood education, the benefits are most pronounced among vulnerable children:

> There is consistent evidence showing the positive impact of high-quality early education and care programs on young children's cognitive and social outcomes and adjustment to school. Importantly, while vulnerable children at risk of school failure seem to benefit most from high-quality early childhood programs, there is also evidence of far-reaching academic and social benefits for all children. Unfortunately…many of the most vulnerable children do not participate in early childhood programs or they attend the lowest quality programs. Similarly, children of working poor families are most often exposed to poor-quality care.[17]

Employment, income and work

2.14 Employment and working conditions have a powerful effect on health equity. Work is cited by the WHO as the key arena 'where many of the key influences on health are played out.'[18] The WHO report argues that 'people's economic opportunity and financial security is primarily determined, or at least mediated, by the labour market.'[19] It goes on to note that when working conditions and access to the labour market are good: '[T]hey can provide financial security, social status, personal development, social relations and self-esteem, and protection from physical and psychosocial hazards.'[20] There are two key ways in which employment and health intersect: access to the labour market, and the nature of the work undertaken.

2.15 There are clear negative health consequences for people unable to access the labour market, or who are precariously engaged in paid employment. Unemployment negatively impacts on the health of both the unemployed person and their family.[21] The health effects of unemployment have been linked to both its psychological consequences and the financial problems it brings, especially debt. The health effects of unemployment begin before a person actually loses their job; the insecurity people first feel when their job is threatened is also detrimental to health. Job insecurity has been linked to mental health (particularly anxiety and depression), self-reported ill-health and heart disease.[22]

2.16 The committee heard that income inequalities not only impact individual health through reducing access such things as services and education, but also provide

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17 Alison Elliott, *Early Childhood Education: pathways to quality and equity for all children*, Australian Council for Educational Research, 2006, p. 23.

18 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 5.

19 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 73.

20 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 5.

21 Council of Social Services NSW, *Submission 44*, p. 12.

22 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 20.

a metric for social inequality more broadly. The Tasmanian Social Determinants of Health Advocacy Network argued that:

> The greater the income inequality in a country, the greater the health and social problems such as life expectancy, obesity, poor education outcomes and so forth.[23]

2.17 The nature and organisation of the available work and workplaces can also impact on the health of an individual. Having little control over one's work is particularly strongly related to negative health outcomes. Similarly, receiving inadequate rewards for the effort expended at work in the form of money, status and self-esteem is associated with increased cardiovascular risk.[24] Physical and psychological health at work are important factors contributing to an individuals' overall health outcomes. It is increasingly recognised that maintaining a healthy work-life balance is important for health and overall wellbeing.[25]

2.18 The clearest outcome of exclusion from the labour market is a lack of money. The committee heard that 'income is probably in everybody's top three' social determinants of health.[26] The impacts of low income on health can be seen through statistics provided by the Australian Social Inclusion Board that indicate that 33 per cent of people in the lowest income quintile reported fair or poor health compared with just 6.5 per cent of those in the highest income quintile.[27] Research by the Australian Council of Social Services provides an insight into the number of low income families in Australia, finding that:

> In 2010, after taking account of household costs, an estimated 2 265 000 people or 12.8% of all people, including 575 000 children (17.3% of all children), lived in households below the most austere poverty line used in international research. This is set at 50% of the median (middle) disposable income for all Australian households…A less austere but still low poverty line, that is used to define poverty in Britain, Ireland and the European Union, is 60% of the median income….When this higher poverty line is used, 3 705 000 people including 869 000 children, were found to be living in poverty. This represented 20.9% of all people and 26.1% of children.[28]

2.19 Poverty, relative deprivation and social exclusion have a major impact on health and premature death. Absolute poverty – a lack of basic material necessities of

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23 Mrs Herzfeld, Facilitator, Tasmanian Social Determinants of Health Advocacy Network, *Committee Hansard*, 12 October 2012, p. 25.

24 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 18.

25 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 80.

26 Mr Symondson, 4 December 2012, *Committee Hansard*, p. 59.

27 Australian Social Inclusion Board, *Submission 65*, p. 4.

28 Australian Council of Social Services, *Poverty in Australia: ACOSS Paper 194*, 2012, p. 7.

life – continues to exist even in wealthy countries. Relative poverty means being much poorer than most people in society and is often defined as living on less than 60% of the national median income.[29] Relative poverty can deny people access to decent housing, education, transport and other factors vital to full participation in life. The stresses of living in poverty are particularly harmful during pregnancy, to babies, children and to old people.[30]

2.20 Receiving a living wage throughout a person's life course was also highlighted by the WHO Report as essential for positive health outcomes. A living wage takes into account the current cost of living, and is regularly updated based on health needs such as adequate nutritious food, shelter and social participation.[31] The WHO Report highlights the benefits of a strong system of social protections:

> Countries with more generous social protection systems tend to have better population health outcomes, at least across high-income countries for which evidence is available…countries with higher coverage and greater generosity of pensions and sickness, unemployment and work accident insurance (taken together) have a higher [life expectancy at birth].[32]

2.21 The committee received evidence that addressing income and employment disadvantage results in better health outcomes in the Australian context. A recent study conducted in the Northern Territory found that lifting socio-economic index scores for family income and education/occupation by two quintile categories for low socio-economic indigenous groups was sufficient to overcome the excess hospital utilisation among the Aboriginal population compared with the non-Aboriginal population in the Northern Territory.[33]

Access to healthcare

2.22 The healthcare system itself is an important social determinant of health that is influenced by and has influence over other social determinants. Australia currently has a universal healthcare system. However, it is well documented that some areas of Australia, and some social groups, are better serviced by health infrastructure than other areas. The NSW Council of Social Services reported that:

> Structural barriers in Australia's health system inhibit equitable access to health care and cause or compound health inequalities. These include health care costs and user fees, unavailability of timely, quality services, and low health literacy. For instance, more than a quarter of people (26.4%) report

29 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 16.

30 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 16.

31 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 78.

32 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 85.

33 Northern Territory Government Department of Health, *Submission 64*, p. 2.

> financial barriers to seeing a dentist, and nearly one in ten people (8.7%) delayed or did not see a GP due to cost. Australians in the most disadvantaged areas have lower rates of dental services, optometry services, and ambulatory mental health services.[34]

2.23 According to the WHO Report, universal coverage means that everyone within a country can access the same range of goods and services according to needs regardless of their level of income or social status.[35] The National Health and Hospitals Reform Commission has highlighted inequalities in healthcare in Australia including gaps in dental, public hospital and mental health services.[36] People living in rural locations with minimal access to healthcare report poorer health outcomes and lower life expectancies than people living in major metropolitan areas.[37] The Australian Institute of Health and Welfare's *Health Workforce 2025* reported that:

> …people living in regional, rural and remote areas exhibit:
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> - 20 percent higher self-reported rates of fair or poor health;
> - 10 percent higher levels of mortality;
> - 20 percent higher rates of injury and disability;
> - 10-70 percent higher rates of perinatal death.[38]

2.24 Although access to most healthcare is subsidised through Medicare to ensure access for all people to medical treatment, assess to certain areas of healthcare appears to remain constrained by income with Professor Friel noting:

> We see this already in Australia – for a given level of need, socio-economically advantaged women are more likely to use specialist medical, allied health, alternative health and dental services than less advantaged women.[39]

2.25 As can be seen from the above examples, the provision of healthcare services, and access to them, are social determinants of health.

The social gradient

2.26 There is a relationship between people's social circumstances and economic wellbeing, and their health, referred to as the social gradient. As explained by Professor Friel, one of the of the WHO Report's authors: 'As one moves down the socio-economic ladder the risk of shorter lives and higher levels of disease risk factors increases.'[40] Researchers have labelled this the social gradient of health.[41] The social

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34 Council of Social Services NSW, *Submission 44*, p. 15.

35 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 8.

36 Professor Friel, Professor of Health Equity, *Submission 2*, p. 2.

37 Professor Friel, Professor of Health Equity, *Submission 2*, p. 2.

38 Australian Institute of Health and Welfare, *Health Workforce 2025*, volume 1, Canberra, 2012, pp 157–158.

39 Professor Friel, Professor of Health Equity, *Submission 2*, p. 3.

40 Professor Friel, Professor of Health Equity, *Submission 2*, p. 2.

gradient is not confined to relatively poor countries. Recent research undertaken in Australia has borne out this trend:

> The NATSEM report that Catholic Health Australia commissioned indicated that a person in the lowest socioeconomic group in Australia can expect to die on average some three years earlier than someone in the highest socioeconomic group. That report also indicated that a person in the lowest socioeconomic group can expect to have twice the prevalence of chronic illness during their life than someone in the highest socioeconomic group.[42]

2.27 Evidence for a social gradient of health was not confined to one problem or group, with one study finding that:

> Socioeconomic differences were found in all the health indicators studied, and were evidence for both men and women and for both age grounds. Health of Australians of working age was found to be associated with socio-economic disadvantage, irrespective of how socio-economic status or health was measured…Household income, level of education, household employment, housing tenure and social connectedness all matter when it comes to health.[43]

2.28 Health outcomes are heavily impacted by the context in which people work, live, and play:

> One of the quite critical issues that comes up around social determinants is the balance between people's personal responsibilities in relation to health and what is socially determined and drives their health. If it were simply up to individuals then you would have no social gradient, basically; you would not be able to see that in your data. It would not matter if somebody were in the top quintile rather than the bottom quintile.[44]

2.29 In other words, without a social gradient of health, a wealthy person would be equally as likely as a poor person to be obese or to experience a range of other health problems. The available evidence indicates however that this is not the case, and it is deduced from this that something other than each individual's decisions must be influencing health outcomes.[45]

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41 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 31.

42 Mr Laverty, Chief Executive Officer, Catholic Health Australia, *Committee Hansard*, 4 December 2012, p. 1.

43 National Centre for Social and Economic Modelling, *Health Lies in Wealth: health inequalities in Australians of working age*, September 2010, p. 35.

44 Ms Sylvan, Chief Executive Officer, Australian National Preventive Health Agency, *Committee Hansard*, 11 December 2012, p. 1.

45 NATSEM, Health Lies in Wealth: health inequalities in Australians of working age, September 2010, pp. 23–29.

2.30 Areas of health showing a strong social gradient are broad including heart disease, diabetes, asthma, mental health conditions and obesity.[46] The underlying objective in social determinants of health theory is to level the social gradient so that health outcomes are not determined by one's place in the economic hierarchy of society, and to improve health by targeting structural factors that can lead to harm.

Education

2.31 A crucial social determinant of health, according to the WHO Report, is ensuring that people have access to quality education throughout their lives. [47]

2.32 For children, the environment into which they are born can play a decisive role in their later scholastic achievements. The socio-economic position of a child's parents has been shown to play a significant role in educational outcomes. This holds true in developed countries with universal education such as Australia. As explained by macroeconomist Joann Wilkie:

> High-income earning parents may be able to purchase or produce better 'inputs' for their children's development. Low-income earning parents cannot offer their children the same quantity or quality of inputs. Studies have shown that children from low-income backgrounds are more likely to have lower educational attainment and earnings in adulthood than those from high-income households.[48]

2.33 Evidence from the United States of America demonstrates the impact of education on the social gradient of health:

> Reports in 2005 revealed the mortality rate was 206.3 per 100,000 for adults aged 25 to 64 years with little education beyond high school, but was twice as great (477.6 per 100,000) for those with only a high school education and 3 times as great (650.4 per 100,000) for those less educated.[49]

2.34 Evidence from the Australian Bureau of Statistics highlighted the positive impact education can have on Indigenous health, finding that:

> In 2008, 59 per cent of Aboriginal and Torres Strait Islander people aged 15–34 years who had completed Year 12 reported excellent/very good health compared with 49 per cent of those who had left school early (Year 9 or below).[50]

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46 Professor Friel, Professor of Health Equity, *Submission 2*, p. 2.

47 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 79.

48 Joann Wilkie, 'The role of education in enhancing intergenerational income mobility', *Economic Round-Up*, Canberra, Spring 2007, p. 84.

49 Catholic Health Australia, *Submission 19*, p. 8.

50 Australian Bureau of Statistics, *4704.0 – The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples*, October 2010, available from: http://www.abs.gov.au/AUSSTATS/abs@.nsf/lookup/4704.0Chapter365Oct+2010, accessed: 18 December 2012.

2.35 For Australia more broadly, data presented by the Department of Health and Ageing (Department) showed clearly that long-term health risk factors such as obesity, diabetes, hypertension and arthritis are higher for early school leavers than those that go on to complete Year 12.[51] Similarly, the *Health Lies in Wealth* report found that: 'Early high school leavers…are 10 to 20 per cent less likely to report being in good health than those with a tertiary education.'[52]

2.36 The importance of education continues throughout a person's life. Access to education enables people to changing jobs or retrain when they are not in work. Education is a major contributor to intergenerational social mobility as individuals who are more highly educated typically receive higher remuneration and the health benefits that brings.[53]

Social security

2.37 The WHO Report emphasized that all people need social protection throughout their lives from infancy and childhood, throughout their working years and in old age, providing surety in times of disability, injury or loss of work.[54] The Report noted that: 'Generous universal protection systems are associated with better population health, including lower excess mortality among the old and lower mortality levels among socially disadvantaged groups.'[55]

2.38 A major obstacle in improving society-wide health outcomes is intergenerational poverty.[56] Children born to parents from lower socioeconomic backgrounds are more likely to do poorly at school,[57] more likely to be unemployed, and more likely to have poor health. Adequate social protection systems can prevent intergenerational poverty and prevent temporary unemployment from becoming entrenched unemployment.

2.39 This chapter has already canvassed the negative health impacts that can be caused by poverty. Recent research indicates that those most likely to be impoverished are reliant on social security payments: unemployed households, single adults over 65 years of age, and households whose main income is social security.[58] The committee heard that unemployment allowances in Australia had not been increased in real terms

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51 Department of Health and Ageing, *Submission 60*, p. 12.

52 National Centre for Social and Economic Modelling, *Health Lies in Wealth: health inequalities in Australians of working age*, September 2010, p. 36.

53 Joann Wilkie, 'The role of education in enhancing intergenerational income mobility', *Economic Round-Up*, Canberra, Spring 2007, pp. 84, 91–92.

54 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 84.

55 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 7.

56 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 7.

57 Janet Taylor and Nina Gee, *Turning 18: Pathways and Plans – Life chances study stage 9*, Brotherhood of St Laurence, 2010, p. 9.

58 Australian Council of Social Services, *Poverty in Australia: ACOSS Paper 194*, 2012, p. 8.

for over two decades, and that now 'over 50 per cent of people living on [Newstart] are living below the poverty line.'[59] The New South Wales Council of Social Services expressed concern that the current levels of income support are insufficient to keep people out of poverty, and therefore out of poor health:

> The [Councils of Social Services] have serious concerns about the inadequacy and inequality of unemployment and income support payments. We believe that it is everyone's right to have access to paid work, and when looking for paid work, to have income support to live with dignity. Yet our social security system is failing to provide people with this basic guarantee, plunging people into poverty.[60]

2.40 While it is important to have sufficient social supports in place to protect people throughout the life cycle, it is also necessary to ensure that there are steps in place to move people from the welfare system to employment. It was pointed out to the committee that in the case of Tasmania, the number of people in receipt of government aid has not changed in a long time, and it is necessary to establish pathways to assist people into employment:

> We do have to find better ways of getting the third of the population who are on income support payments back into the workforce, back into participating in life. For those who have disabilities, et cetera, that does not mean that they are not able to be engaged in work or in social activities. It is important for us to start to look at that more closely and how we can shift that. That 30 per cent figure has not changed in a long, long time and I think it is something we definitely have to look at as well.[61]

Lifestyle factors: food, addiction, stress

2.41 Lifestyle factors that can cause poor heath such as diet, alcohol and tobacco use are often deemed to be, and responded to, as individual factors that should be addressed through individual behavioural change. Professor Friel highlighted for the committee the correlation of environmental factors – in this case social status – on individual health outcomes, explaining:

> The systematic evolution and continuation of the uneven distribution of obesity, tobacco and alcohol use suggests that there is something about the broader society that is affecting people's ability to pursue healthy behaviour, increasingly so with decreasing social status.[62]

2.42 The social determinants approach shifts the focus – and thereby the necessary solution – from the individual to the context.

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59 Dr Goldie, Chief Executive Officer, Australian Council of Social Services, *Committee Hansard*, 23 November 2012, p.26.

60 Council of Social Services NSW, *Submission 44*, p. 12.

61 Mrs Herzfeld, Facilitator, Tasmanian Social Determinants of Health Advocacy Network, Committee Hansard, 12 October 2012, p. 28.

62 Professor Friel, Professor of Health Equity, *Submission 2*, p. 3.

2.43 It was noted by the Northern Territory Department of Health that many of the 'lifestyle' risk factors are exacerbated by other social determinants of health:

> Many of the modifiable risk factors that influence the development of chronic conditions such as smoking, consumption of excess alcohol, poor diet and limited physical activity are linked to the [social determinants of health], and are exacerbated by other [social determinants of health] such as level of income, limited education and unemployment which are risk factors for chronic conditions in their own right.[63]

2.44 A good diet is central to health and well-being. Social and economic conditions result in a social gradient in diet quality that contributes to health inequalities. Food insecurity is not typically considered a problem for countries such as Australia, however levels of food insecurity have been found to impact between 5–10 per cent of the population.[64] Excess intake (also a form of malnutrition) contributes to cardiovascular disease, diabetes, cancer, degenerative eye diseases, obesity and dental caries. The main difference between social classes is the source of the nutrients, with poor demographics tending to substitute cheaper processed food for fresh food. People on low incomes, such as young families, the elderly and unemployed are least able to eat well and are therefore most at risk.[65] One explanation for this trend is provided by the WHO Report:

> Trade liberalisation – opening many more countries to the international market – combined with continuing food subsidies has increased the availability, affordability, and attractiveness of less healthy foodstuffs, and transnational food companies have flooded the global market with cheap-to-produce, energy-dense, nutrient-empty foods.[66]

2.45 Social and psychological circumstances can cause long-term stress which is harmful to human health. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over home and work life have powerful effects on health. Such psychological risks accumulate over life and increase the chances of a person suffering from poor health.[67]

2.46 Alcohol dependence, illicit drug use and cigarette smoking are all closely associated markers of social and economic disadvantage. All three are a significant drain on the financial resources of poorer people and a large cause of health problems and premature death.[68] In Australia, for example, areas of relative disadvantage such

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63 Northern Territory Government Department of Health, *Submission 64*, p. 1.

64 Macarthur Future Food Forum, *Submission 15*, p. [3].

65 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 26.

66 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, pp 134–135.

67 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 12.

68 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 24.

as regional areas show significantly higher rates of alcohol and tobacco use than wealthier metropolitan areas.[69]

Urban design

2.47 The planning and design of urban environments has a major impact on health equity through its influence on behaviour and safety.[70] The WHO Report notes that:

> Where people live affects their health and chances of leading flourishing lives. Communities and neighbourhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being, and that are protective of the natural environment are essential for health equity.[71]

2.48 For the first time in human history more people live in urban than rural areas.[72] The impact of the growing urbanisation on human health will be determined, in many ways, by the decisions regarding how urban areas are developed and maintained. Improvements over the last 50 years in mortality and morbidity in highly urbanised countries such as Japan, the Netherlands, Singapore and Sweden highlight that modern cities can be healthy environments. The above examples also point towards the importance of supportive political structures, appropriately applied financial resources, and social policies that underpin the equitable provision of conditions and services.[73]

2.49 The kind of neighbourhood an individual lives in also impacts on their exposure to crime – which tends to concentrate in specific areas, and availability of and access to appropriate housing and transport.[74] Evidence provided from the Australian Council of Social Services highlighted the impact of income on access to services, noting: 'that there was virtually nowhere in the capital cities that people living on social payments could afford to rent in the private rental market.'[75]

2.50 While there is evidence that urban environments can be places of health, there are also threats to human health. One of the greatest emerging health issues among

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69 Tobacco use is reported to be 24 percent higher, while rates of risky alcohol consumption increases by 32 percent. Australian Institute of Health and Welfare, *Health Workforce 2025*, volume 1, Canberra, 2012, pp 157–158.

70 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 4.

71 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 60.

72 Central Intelligence Agency, *World Fact Book*, available from: https://www.cia.gov/library/publications/the-world-factbook/geos/xx.html, accessed: 19 September 2012.

73 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 63.

74 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, pp 62–66.

75 Dr Goldie, Chief Executive Officer, Australian Council of Social Services, *Committee Hansard*, 23 November 2012, p.26.

wealthy countries is obesity, a problem particularly prevalent among socially disadvantaged groups in many cities throughout the world.[76] The WHO Report argues:

> Physical activity is strongly influenced by the design of cities through the density of residences, the mix of land uses, the degree to which streets are connected and the ability to walk from place to place, and the provision of and access to local public facilities and spaces for recreation and play. Each of these plus the increasingly reliance on cars is an important influence on shifts towards physical inactivity in high- and middle-income countries.[77]

2.51 Transport policy can play a key role in combating sedentary lifestyles by reducing reliance on cars and increasing the number of people who walk, cycle and use public transport. Not only does walking and cycling improve an individual's health, it reduces the cost to society of road deaths and injuries, has a lower environmental impact, and increases social interactions. Urban areas that depend on car use isolate the young and the old.[78] The WHO Report highlights the 'vicious cycle' of growing car dependence, land-use change to facilitate car use, and increased inconvenience of non-motorised transport modes leading to even more car use.[79] The report goes on to call for the prioritisation of walking and cycling over car use in order to address some of the health impacts of existing urban environments.[80]

Social Exclusion

2.52 A person's inclusion in society and control over their destiny are each important for social development and health. Having the freedom to participate in economic, social, political, and cultural relationships has been shown to have intrinsic value.[81] Social exclusion may result from unemployment, discrimination, stigmatisation and other reasons. Poverty and social exclusion also increase the risks of divorce and separation, disability, illness, and addiction. People who live in, or have recently left institutions such as prisons, psychiatric homes and orphanages are particularly vulnerable. The greater the length of time that people live in

76 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 62.

77 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 62.

78 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 28.

79 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 66.

80 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 67.

81 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 157.

disadvantaged circumstances, the more likely they are to suffer from a range of health problems.[82]

2.53 Being included in the society in which one lives is vital to the material, psychological, and political aspects of inclusion that underpin social well-being and equitable health. As noted by the WHO Report:

> Health equity depends vitally on the empowerment of individuals and groups to represent their needs and interests strongly and effectively and, in doing so, to challenge and change the unfair and steeply graded distribution of social resources to which all men and women, as citizens, have equal claims and rights.[83]

2.54 Social support and good social relations make an important contribution to health. Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. Supportive relationships may also encourage healthier behavioural patterns. High levels of social cohesion, defined as the quality of social relationships and the existence of trust, mutual obligation and respect in communities, also help protect a person's health.[84]

Conclusion

2.55 Good health involves improving access to education, reducing insecurity and unemployment, improving housing standards, and increasing the opportunities for social engagement available for all citizens. Addressing the discrepancies of health outcomes resulting from the prevailing social determinants means addressing the causes of those social determinants. The following chapters discuss areas of possible government action to address the social determinants of health in Australia.

82 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 16.

83 Commission on the Social Determinants of Health, 'Closing the gap in a generation', 2008, p. 155.

84 Wilkinson and Marmot, 'Social Determinants of Health: the solid facts', World Health Organization Regional Office for Europe, 2003, p. 22.