‘Building communities where resilience and opportunity can flourish is central to tackling inequality in health. Prevention will have little impact if the social determinants of health are not considered, including factors which result in social exclusion. Key among these is tackling poverty, disability, poor social support and lack of education and skills.’ Schofield

INEQUALITY IS BAD FOR OUR HEALTH

Jo-anne Schofield

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‘Health is clearly one of the most significant ingredients of social inequity, both within societies…. and between societies…’[1]

Despite having a universal health system that is the envy of the world, where you are born in Australia, the sort of work you do, where you live, and whether you’re Indigenous or male or female will impact on how long you live and the quality of your health during your life.

If you are well off and in a reasonably advantaged position in society you can expect to live longer and be less likely to end up in hospital for illnesses like asthma, diabetes, high blood pressure, heart disease and lung cancer.[2]

If you are poor, you are less likely to survive cancer than if you are rich. And if you are one of the 2.5% of Indigenous Australians, then on any given day you are ‘roughly twice as likely to die as a non-Indigenous person of the same age and gender’.[3]

Just as disadvantage contributes to poor health and high mortality, poor health itself can compound social disadvantage. Few people have the resilience to break the cycle of unemployment or poverty when they are unwell. It is usually healthy people who move up the social ladder while the less healthy experience downward social mobility.[4]

This chapter looks at recent research establishing the link between socio-economic disadvantage and poor health. It shows that people’s health and well-being is greatly influenced by factors that can contribute to inequality, such as age, sex, geographical area and disability. Some dimensions of inequality are ‘unavoidable’ (such as age), while others are due to differences in material

resources including access to education, safe working conditions and healthy living conditions in childhood. As most of these are amenable to intervention, they should be avoidable.[5]

INEQUALITY AND PREVENTABLE DEATHS

In Australia the link between higher rates of death and disadvantage has persisted even though our overall health status has improved. The proportion of overall public spending on health has increased from 7.5% of the gross domestic product in 1995–06 to 9.0% of the gross domestic product in 2005–06 (totalling $86,879 million,)[6] but this has not closed the gap in health inequality.

For Indigenous Australians the gap in life expectancy has widened. And across the board the impact of social disadvantage on higher mortality rates has worsened for men, and not improved for women in the decade to 1998–2000.

Tens of thousands of preventable deaths are caused by disadvantage. In 1998–2000 this involved: 1,197 deaths of infants under one year old, 1,491 deaths among 0–14-year-olds, 1,550 deaths among those aged 15–24 years and 18,999 deaths among working age adults (25 to 64 years).[7]

Significantly mortality rates increase commensurate with the level of disadvantage. That is, as 'the circumstances in which people live and work are more detrimental', this leads to greater health risks and worsening health outcomes, including higher mortality.[8]

This not only adds to health costs, it has a profound social cost on families and communities, as well as a loss of economically productive people to society.[9]

EQUAL ACCESS TO HEALTH SERVICES FOR RURAL COMMUNITIES

Inequality in health outcomes is yet to traverse the great divide between urban and regional Australians. People in rural and regional areas generally have shorter lives and more illness than their city counterparts.[10]

Rural and remote families face a higher rate of maternal death, rural women have significantly higher rates of neonatal deaths and remote women have higher rates of foetal deaths.[11]

Workforce shortages impact directly on people's access to early intervention and treatment in rural and remote communities. The number of doctors per person in the city is estimated at two to one compared to those in rural areas.[12] The Australian Nursing Federation (ANF) have calculated a shortage of 5,400 nurses and 600 midwives required to meet the demand in remote locations, out of a total nursing workforce shortage of 19,000.[13]

According to the ANF, nurses and midwifes 'hold the fort' in rural and remote health care; and creating a funding system that recognises this role would alleviate some of the health delivery problems, as would measures to improve nurse retention and professional development, such as scholarships, access to further education and locum support.[14]

THE IMPACT OF MANUAL WORK ON HEALTH

A number of Australian studies have shown that death rates for most conditions are higher for people employed in manual blue collar jobs than for those employed in managerial, administrative and professional occupations.[15]

Blue collar male workers had a 55% higher death rate from all forms of cancers, compared with managers, administrators and professionals, and both male and female blue collar workers had a much higher rate of death due to diseases of the circulatory, respiratory or disgestive system. This trend continues for other causes of death, such as accident, injury and suicide.[16]

In all, if death rates of blue collar workers were the same as those for managers, administrators and professional groups, then 5,642 deaths would have been avoided from 1998–2000.[17]

OUR MENTAL ILLNESS RATES ARE INCREASING

The 2007 National Survey of Health and Wellbeing found that nearly half of all Australian people (7.3 million) had experienced anxiety, affective or substance use disorder at some stage in their lifetime.

The survey did not draw strong conclusions about the impact of social and demographic characteristics on mental health, but it did find that factors such as not being married or in a de-facto relationship, not being in the labour force, and low education all contributed to poorer mental health outcomes.

Certain groups appear more prone to particular mental health problems. Women were more likely to experience anxiety disorder, and for this to last for a period of 12 months; while men had twice the rate of substance abuse disorders that women had. Young females had a higher prevalence of suicidal thoughts than other groups, while homeless people were two and a half times more likely to experience mental disorders than the general population[18] (see Hollows and Keenan's chapter 'Homelessness' in this report).

The worsening state of our mental health has seen a steep rise in disability benefit receipt for mental illness — with almost 30% of new recipients of disability benefits in Australia reporting that they have a mental illness.

The Organisation for Economic Co-operation and Development (OECD) found that working can improve mental health, but the 'mental-health payoff from employment' depends on working conditions and the type of employment contract. There was an improvement in mental health among men who returned to work, only when returning to a very secure job after sickness. There is no evidence that returning to work has a negative impact on mental health for either men or women.[19]

THE HEALTH OF OUR HEALTH CARE SYSTEM

Our expectations of our health system are high and support for improved funding for health services remains strong. Countless polls have shown that people would prefer to forego personal tax cuts so that funds can be channeled into increased funding for health services along with education.

Demand for services has been fuelled by an ageing population while per person expenditure has grown by an average of 3.8% per year in the decade to 2005–06. Australia now spends around $4,226 per person on average on health.[20]

Increased costs have brought about an emphasis on new forms of care such as home care and assisted living supported by on-going basic medical services and medication.[21]

GROWTH OF THE HEALTH AND COMMUNITY SECTOR

The workforce has experienced rapid growth with one in ten people now employed in the health and community sector. In the last five years, 163,700 additional jobs have been created in health and community services, with the largest area of growth in hospitals and nursing homes (46,900 new jobs). At the same time the demand for health services has risen dramatically with presentations to public and private hospitals increasing.

Demand will only continue to grow as our population ages and the need for workers in health will rise in the next five years. Currently 46 per cent of all employees in health and community services are aged 45 years and over.[22] Between now and 2020 around 90,000 nurses will leave work as their age and the physical demands of their occupations reach a point where they can no longer perform their roles.[23]

Health remains a vital area of the economy for women's employment and 79 per cent of the industry workforce is female. This brings with it associated gender workforce and work organisation characteristics, a high part-time workforce, high turnover and under-valuation of skills — all of which is symptomatic of the low status of care in our economy (see Cooper and Baird's chapter 'Women' in this report).

Australia's ability to tackle inequitable health outcomes is greatly hampered by a complex health delivery system traversing Federal and State jurisdictions and private and public health services. In all there are nine departments of health in Australia for just 20 million people.[24]

PRIVATE HEALTH INSURANCE

The Federal Government refunds 30 per cent of the cost of private health insurance. The costs of this scheme have increased from $2 billion a year in 1998 to around $3 billion today, but according to health consultant Mark Ragg there has only been a small increase of people in private insurance in this period (from 43 to 45 per cent). This scheme is funded from general revenue and so the cost is borne by everyone — not just those who have insurance.

Ragg shows that health funds are spending less per member than they were ten years ago, even though the funds have increased their financial reserves. Moreover, increased spending on private insurance hasn't improved pressure on the public system for elective surgery waiting times.[25]

AN INTEGRATED SERVICE MODEL

Health experts, such as Professor John Dwyer have highlighted the effect of jurisdictional inefficiency on the public system and have called for an integrated service model that is created and owned by both the States and the Commonwealth. Such a model would leave the States to address the social determinants of health.[26]

Practitioners and policy makers alike have long recognised the contribution of social, economic and ecological factors to poor health outcomes and are committed to exploring new models of funding, service delivery and care to target disadvantage.

The nursing workforce makes up 55% of the total workforce in health — and has a vital role in delivering new models of services to tackle social exclusion.[27] This requires the removal of legislative, funding and regulatory barriers to nurses working to the full scope of their practice. According to the ANF nursing roles in primary health care are 'fragmented and under-utilised', and there are immense opportunities to integrate current roles across nursing and with other health professionals. An increase in the number of nurse practitioners will improve access to care, boost health outcomes, and assist in retention and job satisfaction among nurses.[28]

LIFESTYLE INTERVENTIONS: PREVENTATIVE PROGRAMS

A large swag of health prevention policy over the past decade has targeted individual behaviour or has blamed 'lifestyle' choices such as poor diet, obesity, smoking and alcohol use for the consequent poor health outcomes among disadvantaged groups.

Evidence shows that community prevention programs and targeted interventions mostly succeed among more advantaged groups and have often failed to reach the most at risk groups who may make less use of preventative services. This suggests the need for a different approach.[29]

THE PRIMARY HEALTH CARE MODEL

In New Zealand the model of Primary Health Organisations brings together doctors, nurses, allied health professions, counsellors, psychologists and dieticians to provide holistic, patient-centred care. There are now 81 PHOs and the minimum requirements for funding specify that PHOs give communities the opportunity to have a say about the services that are provided.[30] A similar model in Australia is the Aboriginal Community Controlled Health Centre, which provides comprehensive care with community governance. Another is the Community Health Centre model in Victoria — a multi-disciplinary patient care approach that involves several health professionals.[31]

Health stakeholders have concluded that prevention will have 'little impact if the social determinants of health are not considered, including factors which result in social exclusion'. Key among these are tackling poverty, disability, poor social support and lack of education and skills.[32]

Building communities where resilience and opportunity can flourish is central in tackling inequality in health. Thus, treating the causes of health inequality is about more than improving the treatment of illness. It's about making sure all Australians can lead healthy lives, irrespective of where they live, the work they do, their income, wealth, or their cultural background.

JO-ANNE SCHOFIELD, July 2, 2009. Jo-anne is Executive Director of Catalyst Australia Inc., a position she took up in November 2007.

KEEP IN TOUCH WITH THIS TOPIC

Australian Health Care Reform Alliance www.healthreform.org.au

Australian Institute of Health and Welfare www.aihw.org.au

Australian Nursing Federation www.anf.org.au

M. Ragg *Fine, but not fair: A report on Australia's health and health care system.* Sydney: Ragg Ahmed . 2009 www.raggahmed.com

Just released… *Healthy, wealthy and wise? The relationship between health, employment and earnings in Australia,* Binod Nepal, Alicia Payne, Laurie Brown, AMP and National Centre for Social and Economic Modelling (NATSEM), July 2009

ENDNOTES

1 Lord Patten of Barnes, Chancellor, University of Oxford, 'ABC background briefing,' 7th June 2009 www.abc.net.au

2 M. Ragg *Fine, but not fair: A report on Australia's health and health care system.* Sydney: Ragg Ahmed . 2009

3 M. Ragg op cit, pages 18–19. Ragg points out that Indigenous people make up about 2.5 per cent of Australia's total population, but account for about 20 per cent of the deaths in babies under the age of one, and about 15 per cent of deaths up to the age of 45.

4 G. Draper, G. Turell & B. Oldenbury *Health Inequalities in Australia: Mortality.* Health Inequalities Monitoring Services No. 1. AHIW Cat PHE 55 Canberra, Queensland University of Technology and Australian Institute of Health and Welfare page 127, 2004

5 Australian Institute of Health and Welfare (AIHW), *Australia's Health 2008*, Canberra, Cat. no. AUS 99, page 63–64, 2008.

6 ibid page 396. Over the decade, real growth in health expenditure has increased an average of 5.1% a year after accounting for the effects of inflation.

7 G. Draper et al, page 94.

8 G. Draper et al. pages 91–94. The death rates in the most disadvantaged areas were 14% higher than the least disadvantaged areas in 1985–87 and were 17% higher in 1998–2000. See also M. De Looper and G. Lafortune *Measuring Disparities in Health Status and in Access and Use of Health Care in OECD Countries,* OECD Health Working Papers No. 43, 9 March 2009.

9 Ibid, Chapter 5, page 94

10 AIHW, op cit 62.

11 Department of Health (2009), *Improving maternity services in Australia,* February 2009 www.health.gov.au. The review report found that Australia was one of the safest countries to give birth but maternity services were not meeting the needs of many women.

12 M. Ragg, op cit.

13 Australian Nursing Federation (ANF), Scholarships for a Competitive Future: Expansion of the Commonwealth Scholarships Program, May 2008 page 3. The ANF says that around 30% of the 285,620 strong nursing profession works in rural and regional areas.

14 ANF 'Submission to the National Health and Hospitals Reform Commission,' June 2008.

15 G. Draper et al, op cit, Chapter 6. Conditions include all cancers, diseases of the circulatory, respiratory or digestive system, accidents and injury, suicide.

16 Ibid, page 99. There are some distinctions between managers, administrators and professionals and other white collar workers, but these are not as significant as those mentioned.

17 Ibid, page 104. It is noted that estimates in the report are likely to be smaller than the true magnitude of occupational differences in mortality. Socio-economic factors, such as education and income may also impact along with occupation.

18 Australian Bureau of Statistics *National Survey of Mental Health and Wellbeing: Summary of Results,* Cat 4326.0; Department of Health, *National Survey of Health and Wellbeing, An Overview of Mental Disorders in Australia,* Chapter 2 'The Mental Health of Australians 2', 2007. The survey covers affective disorders (mild, moderate and severe depression, dysthymia, and bipolar affective disorder); anxiety disorders (panic disorder, agoraphobia, social phobia, generalised anxiety disorder,obsessive-compulsive disorder and post-traumatic stress disorder); and substance use disorders (abuse or harmful use and dependence on alcohol, cannabis, opioids, sedatives and stimulants).

19 OECD *Are all jobs good for your health? The impact of work status and working conditions on mental health,* Chapter 4, and OECD Economic Outlook 2008 *How does your country compare?* — Australia www.oecd.org.au

20 AIHW, op cit, page 404. Note per person expenditure is funded by Government, by non-Government organisations such as private health insurance funds, and by individuals through out-of-pocket expenses.

21 R. Fujisawa and F. Colombo, 'The Long-Term Care Workforce: Overview and Strategies to Adapt Supply to a Growing Demand,' OECD *Health Working Papers No. 44,* 19 March 2009, page 14.

22 Department of Education, Employment and Workplace Relations *Australian Jobs 2008* www.workplace.gov.au. 2008. Note that growth figures include community service occupations such as child-care.

23 Kronos Incorporated *Research Confirms Australian Nurses on Endangered Species List,* 22nd October, 2008

24 Professor J. Dwyer, 'Address to Crunch time: Australia's Policy Future conference,' Sydney April 2009 www.crunchtime.org.au

25 M Ragg,, op cit pp 15–19.

26 Professor J. Dwyer, op cit.

27 ANF Submission to the National Preventative Health Taskforce Discussion Paper,' January 2009

28 ANF, May 2008 op cit

29 See J. Furler and D. Young op cit and G. Draper et al, pp 127–129

30 ANF June 2008 and New Zealand Ministry of Health, *Primary Health Care and PHOs* www.moh.govt.nz/primaryhealthcare

31 ANF June 2008; ANF Response to the National Health and Hospital Reform Commission's Interim Report: 'A Healthier future for all Australians' March 2009

32 ANF January 2009 op cit.