

Catholic Health Australia

**The central place of Health in Australia's  
Social Inclusion Agenda:  
*Addressing the Social Determinants of  
Health to achieve social inclusion***

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**Australia**

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## Foreword

Why is it that the wealthy are healthy? Why when it comes to health do the poor suffer more?

A person's health is strongly influenced by that person's wealth. In days past, we thought this was because higher incomes meant better access to health care. We thought this was why the rich lived longer. Today we know more.

A long succession of research indicates a person's health is first influenced by their time in the womb. We know the early years of childhood define a lifetime's health expectations. We know educational attainment, participation in the workforce, and income levels all influence people's health outcomes. Yet in Australia when we talk about health we immediately think of nurses, doctors, and hospitals. We don't immediately think of vibrant childhoods, good schooling, satisfying work lives and fairness in income. Our thinking needs to change.

Despite obvious problems, we have one of the best health care systems in the world. Yet when health reform is considered in Australia, we tend to focus only on immediate problems. Our immediate problems are many – a health workforce shortage, rising costs of care, and an increasing demand on services as our population ages and becomes more obese. We have failed as a nation to properly consider the root causes of most illness and disease. We have failed as a nation to properly act to better influence the social determinants of health.

This Catholic Health Australia (CHA) Policy Paper of January 2009 draws together recent research on the social determinants of health. Put simply, determinants are those factors that most influence a person's health and life expectancy. In this Policy Paper, CHA argues that social factors such as a person's level of education, their home life, and their financial resources are in some cases stronger influencers on a person's health and wellbeing than biomedical factors. In a country like Australia, a person's health should not depend on their personal wealth. Our current approach to health needs to change.

Change needed to improve the health of those in socioeconomic disadvantage does not need to take place in hospitals. It does not need to take place in doctors' surgeries. The change required needs to take place outside the traditional health system. For this to occur, we need new thinking of government.

The Australian Government is pursuing a social inclusion agenda. Social inclusion is already a cornerstone of government thinking within some States and Territories. CHA argues the Australian Government's social inclusion agenda should use the social determinants of health as building blocks for policy directions. In particular, CHA argues the Australian social inclusion agenda should be built on the recommendations of the World Health Organisation's Commission on Social Determinants of Health.

This Policy Paper is one of several contributions CHA intends to make on the need for action to address the health needs of those living in socioeconomic disadvantage as part of our work to fulfil our Ministry of Catholic healthcare. We are grateful for the support of the St Vincent de Paul Society and Catholic Social Services Australia, with who we will partner to seek improved outcomes for the health of Australians in need.

**Tony Wheeler**  
Chairman, Catholic Health Australia

## Abstract

Socioeconomic factors have a direct bearing on how long a person lives, and the burden of disease they will be exposed to. Those of low socioeconomic status fare the worst. The social determinants of health include early childhood experiences, educational attainment, employment status, income, and living conditions. These factors in some cases have a greater impact on personal or population health than biomedical and behavioural risk factors. Most social determinants of health can be modified to improve personal and population health outcomes. Yet modifying the social determinants of health requires action outside the boundaries of the traditional health system. The development of a social inclusion agenda in Australia gives rise to an opportunity to address the social determinants of health. Addressing the social determinants of health through the social inclusion agenda may in fact be the most practical method by which a socially inclusive society can be achieved.

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## About Catholic Health Australia

Twenty-one public hospitals, 54 private hospitals, and 550 aged care facilities are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at [www.cha.org.au](http://www.cha.org.au).

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## Introduction: A new approach to health as part of a social inclusion agenda

Social inclusion is achieved when all people within a community feel valued, their differences are respected, and their basic needs are met such that they live in dignity.<sup>1</sup> Social exclusion results in being shut out of the life of the community: excluded from social connections, economic processes, and political and cultural networks that bind individuals.<sup>2</sup>

Social inclusion has taken as its meaning a process by which governments can seek to overcome those factors that cause social exclusion. As the Australian Government commences implementation of social inclusion policies, this policy paper outlines the opportunity for a new approach to population health as a component of Government efforts to help achieve a more inclusive society.

The use of social inclusion as a framework for social policy analysis occurred first in Australia in 1999.<sup>3</sup> Since that time, the States of South Australia, Tasmania, Victoria, and the Australian Capital Territory have put in place social inclusion frameworks to guide government policy and program development. Most recently, the Australian Government established in December 2007 the positions of Minister and Parliamentary Secretary for Social Inclusion, and a supporting Unit within the Department of Prime Minister and Cabinet. In May 2008 the Australian Government also established the Australian Social Inclusion Advisory Board.<sup>4</sup> Within this context, the use of social inclusion as a tool for policy development is in its infancy within Australia.

Social inclusion is recognised as a key social determinant of health.<sup>5</sup> The social and physical environments in which people live determine their health.<sup>6</sup> Higher socioeconomic status is also associated with better health.<sup>7</sup> The social determinants of health are primary influencers on population health.<sup>8</sup> With the development of Australia's social inclusion framework still in its early stages, Governments have the opportunity to define the contribution that a new approach to health can make to achieve a more inclusive society. In fact, a social inclusion framework would be incomplete if a new approach to health was not one of its core tenets.

There is substantial literature on the social determinants of health. There is limited but growing literature on social inclusion. By way of select review of this Australian and international literature, this policy paper seeks to outline the need to address the social determinants of health as a key component of the development of Australia's social inclusion agenda.

In part one this policy paper considers the current status of the health and wellbeing of those living in social exclusion in Australia and other countries. In part two this policy paper explores the role of the determinants of health and their link with social exclusions. In part three this policy paper concludes by outlining how governments within Australia can incorporate action on the social determinants of health as part of social inclusion policy.

## Part 1: The state of health of the socially excluded

Average life expectancy in Japan and Sweden is 80 years; in Brazil it is 72 years; in India it is 63 years; in most African nations it is 50 years.<sup>9</sup> The wealth and development status of these countries directly correlates to the average life expectancy of their citizenry. The more developed and wealthier the nation, the more likely it is that their residents will live longer. Health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.<sup>10</sup>

Average life expectancy for an Australian male at birth is 77 years, and for a female is 82 years.<sup>11</sup> Aboriginal Australians have a life expectancy of 59 years for males and 65 years for females. The current difference in life expectancy of these two groups is 17 years.<sup>12</sup>

The 17-year average gap in life expectancy of Aboriginal and non-Aboriginal Australians is a stark demonstration of how socioeconomic status influences different health attainment within Australia. Disadvantaged Australians on average have shorter lives, higher levels of disease risk factors and lower use of preventive health services than those less disadvantaged Australians.<sup>13</sup> Within communities, people with higher income generally enjoy better health and longer lives than people with lower income.<sup>14</sup>

There is a strong association between mortality and income inequality, both between geographical areas within countries and between countries<sup>15</sup>, and Australia is not the only country within which this results in a more than ten-year disparity in life expectancy of different socioeconomic groups. The National Interim Life Tables indicate a person residing in the socially advantaged United Kingdom suburbs of Kensington and Chelsea in London have average life expectancies at birth of 83.7 years for males and 87.8 years for women.<sup>16</sup> In the more disadvantaged United Kingdom suburbs of Glasgow in Scotland the average life expectancy for males is 70.8 years and for females is 77.1 years.<sup>17</sup> The difference in male life expectancy for

residents of Manchester and London is 10.3 years<sup>18</sup>, and the two areas are separated by only 200 miles or a three and half hour car journey. Importantly, in the period between 1993 and 2005, life expectancy had improved across all regions in the United Kingdom, with males living an additional 3.6 years and females living an additional 2.7 years.<sup>19</sup> It was within this very period that the British Government was implementing policies to overcome social exclusion.

Within Australia, similar disparities in life expectancy can be found depending on the affluence and composition of the community within which a person lives. In the period 2002 to 2006, the 2008 Report of the NSW Chief Health Officer<sup>20</sup> found the average life expectancy at birth for a male resident of NSW was 78.7 years and 83.7 years for a female. For residents of the Northern Sydney and Central Coast Area Health Service - which is home to some of NSW's most affluent residents - life expectancy for males was 80.3 years and 84.5 years for females. In the Greater Western Area Health Service; home to some of NSW's least affluent; life expectancy for males was 76 years and 81.9 years for females. This represents a difference of 4.3 years in life expectancy for males and 2.6 years for females.

Potentially avoidable mortality is a more refined measure of health inequalities as it considers deaths that could have been avoided by improved access to the health system or through the primary prevention of disease through population health interventions.<sup>21</sup> In the period 2002 to 2006, the 2008 Report of the NSW Chief Health Officer<sup>22</sup> found avoidable mortality rates were substantially higher in lower socioeconomic status groups across NSW. Compared with the highest group, the lowest group experienced excess potentially avoidable mortality of 101.5 male and 48.8 female deaths per 100,000 population.

Findings of the Australian National Health Survey (NHS) have been used on several occasions to demonstrate the higher

prevalence of chronic disease within socioeconomically disadvantaged communities. Glover et al utilised the 2001 NHS to identify that the largest chronic disease differential between the most advantaged geographical areas and the most disadvantaged areas was diabetes mellitus. Diabetes mellitus was found to exist at rates in excess of two and a quarter times higher in the most disadvantaged areas.<sup>23</sup> Findings of the 2005 NHS indicate similar results, with the prevalence of circulatory system diseases being almost twice as high in the most disadvantaged grouping compared to the highest.<sup>24</sup>

The NHS also demonstrates the prevalence of health risk factors within disadvantaged communities. Glover et al found a number of risk factors for chronic diseases, including smoking, excessive alcohol use, sedentary behaviors and excess weight, to be linked to socioeconomic status.<sup>25</sup> The 2004-05 NHS also indicated people with lower socioeconomic status are more likely to smoke, exercise less, be overweight and have fewer daily serves of fruit.<sup>26</sup> These are risk factors for conditions including cardiovascular disease, lung cancer, and respiratory diseases.<sup>27</sup>

## Part 2: The social determinants of health

Social health determinants are factors in society or in our living conditions that contribute to good or bad health.<sup>28</sup> These determinants have been described as causal pathways or chains that affect health.<sup>29</sup> Some argue the influence of social determinants on health are greater than biomedical and behavioural risk factors.<sup>30</sup>

There is an abundance of literature on social determinants of health. One of the most exhaustive and recent assessments of the social determinants of health is the World Health Organisation's report of the Commission on Social Determinants on Health. The 2008 report took a holistic view of social determinants of health saying "The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services."<sup>31</sup>

An earlier report of the World Health Organisation cited ten key social determinants of health as being the social gradient, stress, early life, social exclusion, work, unemployment, social support, addiction, food, and transport.<sup>32</sup>

The term 'social gradient' recognises that people "further down the social ladder run at least twice the risk of serious illness and premature death as those near the top."<sup>33</sup> The negative effect of the social gradient is not confined only to those living in poverty, as the choice of occupation has been found to influence life expectancy. A study conducted in the period 1997 to 1999 found life expectancy for a male in England was 78.5 years for a professional worker, 76 years for a skilled non-manual worker, and 71 years for an unskilled manual worker.<sup>34</sup> The study found similar differences in life expectancy for females as linked to their choice of profession, although the differences were less dramatic.

Raphael describes the social determinants of health as the primary influencers on population health, by offering ten factors as the main social determinants of health within developed societies: early life, education,

employment and working conditions, food security, health services, housing, income, social exclusion, social safety net, and employment security.<sup>35</sup>

The American College of Physicians has listed those social determinants of health that it considers as more important to health outcomes than levels of access to primary health care. A paper of the College stated "First, job classification, a measure of socioeconomic status, was a better predictor of cardiovascular death than cholesterol level, blood pressure, and smoking combined in employed London civil servants with universal access to the National Health Service. Second, disparities in health according to socioeconomic status widened between 1970 and 1980 in the United Kingdom despite universal access (similar trends were seen in the United States). Third, in the United States, noncompletion of high school is a greater risk factor than biological factors for development of many diseases, an association that is explained only in part by age, ethnicity, sex, or smoking status. Fourth, level of formal education predicted cardiovascular mortality better than random assignment to active drug or placebo over 3 years in a clinical trial that provides optimal access to care."<sup>36</sup>

Sweden enjoys the second longest life expectancy in the world, behind that of Japan. The Government of Sweden defined the social determinants of health in 2003 by legislating eleven objectives for the public health system to achieve in order to reduce the adverse impacts of the social determinants of health. The eleven objectives are: participation and influence in society, economic and social security, secure conditions during childhood and adolescence, healthier working life, healthy and safe environments and products, health and medical care that more actively promotes good health, protection against communicable diseases, safe sexuality, increased physical activity, good eating habits and safe food, and reduction in tobacco, alcohol, drug use and excessive gambling.<sup>37</sup>

The Swedish legislation represented a departure from Sweden’s earlier approach of building policy in response to specific diseases. It also meant that the majority of public health work would need to take place outside traditional medical care service environments in recognition that most of the factors that impact health are found outside the spheres of medical practice.<sup>38</sup>

A 2001 Australian National Public Health Partnership has described the social determinants of health as including poor intrauterine conditions, stress, violence, educational disadvantage, inadequate living environments that fail to promote healthy lifestyles, poor diet and lack of exercise, alcohol misuse and lack of exercise, low socioeconomic status, discrimination, and unemployment.<sup>39</sup>

The more recent work of the Australian Institute of Health and Welfare has produced a framework for the social determinants of

health. The framework indicates that the four components of society, socioeconomic conditions, health behaviours, and biomedical factors mix with a person’s individual physical and psychological makeup to produce the individual’s and, in turn, the population’s health outcome.<sup>40</sup> The framework is outlined at Table 1.

Whereas there are subtle differences in definitions for the social determinants of health, there is also significant commonality. Common to each definition is the opportunity for adverse determinants to be prevented. Marmot and Wilkinson argue “Good health involves reducing levels of educational failure, reducing insecurity and unemployment and improving housing standards. Societies that enable all citizens to play a full and useful role in the social, economic and cultural life of their society will be healthier than those where people face insecurity, exclusion, and deprivation.”<sup>41</sup>

Table 1: Framework for determinants of health

Society	Socioeconomic	Health Behaviours	Biomedical	An individual's and a population's health
Culture	Education	Smoking	Blood pressure	
Resources	Employment	Physical activity	Blood cholesterol	
Systems	Income and wealth	Alcohol consumption	Body weight	
Policies	Family, neighbourhood	Use of illicit drugs	Glucose regulation	
Affluence	Access to services	Dietary behaviour	Immune status	
Social cohesion	Housing	Sexual behaviour		
Media	Knowledge	Vaccination status		
Natural environment	Attitude	Psychological factors		
Built environment	Beliefs	Safety factors		
Individual physical and psychological makeup (genetics, ageing, life course, intergenerational influencers)				



### Part 3: Implications for Australia's social inclusion agenda

The burden of disease and preventable deaths within Australia attributable to socioeconomic inequality currently results in avoidable disability, the loss of productive members of society, and increased costs for the health and social welfare systems.<sup>42</sup> Yet the many millions of dollars spent to prevent and reduce the prevalence of chronic diseases and their risk factors have not resulted in the defeat of these inequities, just as they have not been defeated in most of the world's developed countries.<sup>43</sup>

Lessening the burden of disease and preventable deaths requires the social determinants of health to be newly recognised. They are being better understood by health professionals and parts of health bureaucracies, but health professionals and their bureaucracies are not perfectly placed to address the determinants of health. It is within schools, workplaces, community groups, welfare agencies, and - most importantly - political environments that the determinants of health can be best addressed. Health professionals and health policy makers have a central role to play, but their work can only succeed when it is done in partnership with those able to influence the economic and social dynamics of the broader community.

The socioeconomic environment can be modified via new approaches to public policy<sup>44</sup>, and the development of social inclusion frameworks by the Australian, State, and Territory Governments provides an opportunity for a new commitment to be made in addressing adverse social determinants of health. In fact, Australia's social inclusion agenda would be incomplete if it did not place the social determinants of health at its core.

Addressing the social determinants of health aligns with the intent of the Australian Government's aspirations for its social inclusion agenda. The Minister for Social Inclusion has said that the social inclusion agenda seeks to give all Australians the opportunity to "secure a job, access services, connect with others, deal with personal crises such as ill health, and to

have their voice heard." Each of these aspirations are social determinants of health.<sup>45</sup>

In incorporating a focus on the social determinants of health into Australia's social inclusion agenda, the Australian Government should:

**1 - Implement recommendations of the World Health Organisation's Commission on Social Determinants of Health**

**2 - Legislate for improvement in the social determinants of health**

**3 - Establish a Health Access Ombudsman**

**4 - Empower policy makers outside health to play a role in addressing the social determinants of health**

**5 - Resource agencies supporting the disadvantaged to play a role in improving adverse social determinants of health**

**1 - Implement recommendations of the World Health Organisation's Commission on Social Determinants of Health**

The Commission's detailed report contains three principles for action, and these principles offer to the Australian Government a framework for achievement of its social inclusion agenda: 1) Improve the conditions of daily life - the circumstances in which people are born, grow, live, work, and age. 2) Tackle the inequitable distribution of power, money, and resources - the structural drivers of those conditions of daily life, globally, nationally, and locally. 3) Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about social determinants of health.<sup>46</sup>

These principles should be adopted for the Australian context to provide a basis for

developing social inclusion policy and programs. A Parliamentary Inquiry could be established to provide advice to the Government on the local adoption of the Commission's recommendations.

The recommendations of the Commission were partly targeted at developing nations with life expectancies almost half of that enjoyed by most Australians. Yet the Commission also targeted Australia with a call to action, by including within its recommendations reference to the disparity in life expectancy between Aboriginal and non-Aboriginal Australians, and by commending the social inclusion initiatives of the state of South Australia which requires a 'health in all policies' assessment to be undertaken before any major decision of government is made.<sup>47</sup>

## **2 – Legislate for improvement in the social determinants of health**

The Swedish Government in 2003 made its commitment to addressing the social determinants of health by passing as law the *Public Health Objectives Act (2003)*. Similarly styled Australian legislation would require all government policy to reflect the need to consider the social determinants of health. The legislation could be based on the local adoption of appropriate recommendations of the World Health Organisation Commission. The legislation should ultimately lead to the creation of government programs aimed at achieving improvements in the health gradient of all Australians. A Parliamentary Inquiry could be established to provide advice to the Government on the drafting of legislation. In the absence of legislation, consideration could be given to adopting the South Australian practice of utilising a 'health in all polices' assessment tool, which could require government to give consideration to the impact of any major decision on the social determinants of health.

## **3 – Establish a Health Access Ombudsman**

One of the specific recommendations of the World Health Organisation Commission is the establishment of a national health equity surveillance framework. In its submission to the National Health and Hospital Reform

Commission, Catholic Health Australia proposed the establishment of an Ombudsman or Commissioner to independently monitor and report to the Federal Parliament on the health of socioeconomically disadvantaged Australians and their barriers in access to health services.<sup>48</sup> The World Health Organisation Commission has similarly proposed the development of a surveillance framework that captures information on health inequities, health outcomes, determinants, and consequences of ill health (the framework is contained at Appendix 1). The Commission proposes that this information be reported to inform responses of governments. The creation of an Australian Health Access Ombudsman or Health Equity Commission would achieve this recommendation of the World Health Organisation Commission, and is easily achievable within Australia's health system.

## **4 – Empower policy makers outside health to play a role in addressing the social determinants of health**

Health policy is currently viewed as being separate from economic, education, employment, welfare and social policy development. The majority of the determinants of health are directly influenced by factors beyond the control of health policy and health care providers. To drive improvement in life expectancy and the lessening of the burden of disease, economic policy and economic programs will need to be informed of the determinants of health. Social security services, schools, employers, welfare agencies and others have a role to play in improving health, and the policy that governs these areas of human service and support needs to be informed of their role in addressing the determinants of health. The social inclusion agenda, with its whole of government approach, can enable this new joined up approach to improving health outcomes.

## **5 – Resource agencies supporting the disadvantaged to play a role in improving adverse social determinants of health**

Addressing social determinants of health means the vast majority of future health work must take place outside the traditional

confines of the health system.<sup>49</sup> Doctors, nurses, and allied health professionals are capable of delivering primary and preventive health services, but addressing the broad range of social determinants of health will require new partnerships with non-health service agencies. To this end, those agencies which interact with people at the low end of the socioeconomic gradient will have a new role to play in advancing the health and wellbeing of their clients. Welfare agencies, educational institutions, employers, and other touch points with people of low socioeconomic standing will need new strategies, new capabilities, and enhanced abilities to help achieve the objects of the social inclusion agenda.

### Next Steps

The purpose of this paper was to propose to the Australian Government the benefit of using the social determinants of health as building blocks for social inclusion programs.

During 2009, Catholic Health Australia will further develop propositions for action on social determinants of health to better inform public policy. This work, which will involve a further literature review and national expert consultation process, will explore what evidence exists to support targeted interventions aimed at improving the health of people in socioeconomic disadvantage.

### Appendix 1: WHO National Health Equity Surveillance Framework

Health Inequities	Health Outcomes	Determinants	Consequences of ill-health
Health outcomes stratified by sex, education, income, wealth, occupation, ethnic group, place of residence	Mortality (all cause, cause specific, age specific)	Health behaviours including smoking, alcohol, physical activity, diet and nutrition	Economic consequences
Distribution of population across the sub-groups	Mental Health	Physical and social environment (water and sanitation, housing conditions, transport, urban design, air quality, social capital)	Social consequences
Relative index of inequality	Morbidity and disability	Working conditions (material hazards, stress)	
Measure of absolute health inequity	Self-assessed physical and mental health	Health care (access, and health care system infrastructure)	
	Cause specific outcomes	Social protection	
		Structural drivers of health inequity	
		Gender	
		Social inequities	
		Socio-political context (civil rights, employment conditions, governance and public spending priorities, macroeconomic conditions.	

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