Public Health Association of Australia:
Policy-at-a-glance – Health Inequities Policy

Key message: PHAA will –

1. Work within and beyond the health system to:
   - Reduce health inequities in Australia, Asia Pacific countries and globally;
   - Promote equity-informed economic and social planning for health development;
   - Seek commitment from governments to develop policies and frameworks that reduce health inequities.
2. Engage with national and international public, non-government and private organisations, civil society, industry, and grass roots movements to build support for policies that reduce local and global health inequities.

Summary: This policy underpins a range of PHAA policies and relates to broader public health directions outlined by the World Health Organization Commission on Social Determinants of Health, the Universal Declaration of Human Rights (UDHR) and other international conventions and declarations. All public health activities and related government policy should be directed towards reducing social and health inequity nationally as well as internationally.

Audience: Australian governments at all levels (federal, state and territory and local), policy makers and program managers, industry, and civil society organisations.

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

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Health Inequities Policy

This policy can be applied across all Public Health Association of Australia (PHAA) policies. PHAA policies aimed at improving health outcomes for particular groups or with respect to particular issues can be found on the PHAA website (www.phaa.net.au)***, under the relevant PHAA Special Interest Groups (SIGs).***

Many SIGs have a national focus, while others such as the Health Promotion, International Health, and Political Economy of Health SIGs support broader global responsibility and action to reduce international health inequities. These are linked to broader health related groups or charters, such as United Nation (UN) instruments and World Health Organization (WHO) documents.

The PHAA notes that:

1. Health inequity differs from health inequality. A health inequality arises when two or more groups are compared on some aspect of health and found to differ. Whether this inequality (disparity) is inequitable, however, requires a judgement (based on a concept of social justice) that the inequality is unfair and/or unjust and/or avoidable. Inequity is a political concept while inequality refers to measurable differences between (or among, or within) groups (1).
2. Health inequity occurs as a result of unfair, unjust social treatment – by governments, organisations and people (2), resulting in macro politico-economic structures and policies that create living and working conditions that are harmful to health, distribute essential health and other public services unequally and unfairly, preventing some communities and people from participating fully in the cultural, social or community life of society.
3. In addition to the health sector, many sectors and people play roles in determining the distribution of the determinants of health and must, therefore, be engaged in intra-sectoral and cross-sectoral partnerships to reduce inequity (3).
4. Excess morbidity and mortality, self-reported health and risk factors for many chronic diseases are associated with socioeconomic disadvantage (4, 5, 6, 7) and with persistent, systematic social exclusion, and must be addressed outside as well as within the health system.
5. The cost of government inaction on distributing the social determinants of health fairly and justly within populations is substantial; gains from enabling more Australians who want paid employment to access meaningful paid work could close the gap in self-assessed health status between most and least disadvantaged Australians of working age and could generate AUD$ 6 to 7 billion per year in extra earnings (8).
6. The early years of life are crucial to the health and life chances of individuals and the health impacts of social and economic deprivation (or sufficiency) accumulate across the life course (3, 9, 10). Maintaining health and capacities in the later years of life is essential to productivity and sustainability in a rapidly ageing Australia (11).
7. Health inequities exist both within and between countries (3, 12-13). Aboriginal peoples and Torres Strait Islanders have experienced the greatest social, economic, political and cultural deprivation of all population groups in Australia – the health consequences of which have been

profound. While socioeconomic status is the most significant determinant of health inequities, population groups of particular concern include homeless people, people affected by chronic mental illness, alcohol and other drug addictions or disability (and their carers), people with insecure low-paid employment, or who are not participants in the paid workforce, people living in remote areas, and some immigrant groups.

8. There is evidence that health inequities may be increasing in Australia (11, 12). At the global level, trends in life expectancy provide some insight into the trends in inequity. Life expectancy in the world's poorest countries is low (45 or 50 years), while higher levels (75 or 80 years) are seen in the richer countries, but the distribution of life expectancy has become wider and more skewed. In 1980, life expectancy was above the world average in six regions (Western Europe, transition economies, Western offshoots, Latin America and the Caribbean, China and Japan), and below average in four (East Asia excluding China and Japan, South Asia, sub-Saharan Africa, Middle-East and North Africa), and the gap in life expectancy between the top and bottom of the distribution (Japan and sub-Saharan Africa) was about 29 years. By 2000, sub-Saharan Africa and South Asia were the only two regions below the world average, and the gap between the top and bottom had increased to 34 years (16). The absence of specific indicators and measurement of health determinants hinders the ability to measure progress towards reducing health inequities across population groups (17). Improvement in general population health outcomes may obscure the changes within specific groups.

9. Richer countries, with a lower disease burden, use more health resources than poorer countries with a higher disease burden (18). However, even within developed nations that have an established public health system, cost-effective interventions to improve life expectancy are not adopted on a scale required to close the inequities gap because adequate funding is generally not committed (19).

10. Free market economic approaches to health care provision have been shown to widen socio-economic and health inequities. There can be, however, a place for a limited market approach, or private sector, in health care planning and delivery as long as accountability measures are established by governments to ensure that there is no increase in inequity, consumer exploitation or rising health care costs, or that such problems can be identified early and addressed (20-22).

11. Climate change and environmental degradation are closely linked with health inequity as the adverse impacts are unequally distributed and the burden is borne disproportionately by those who are already of lower socioeconomic status, poor health, advanced age, and lacking access to appropriate housing (23).

12. International human rights instruments place obligations on States to ensure the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (24). Australia is an original signatory to the Universal Declaration of Human Rights, and continues to promote and protect human rights (25). Other international declarations that include obligations relevant to health inequities include the UN Covenant on Civil and Political Rights, the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), the UN Declaration on the Rights of Indigenous Peoples and the UN Convention Against Torture.

The PHAA affirms the following principles:

13. Providing equal opportunities to access social, economic and environmental conditions and health services that sustain and promote the highest attainable state of health is a fundamental responsibility of governments and societies (26, 27).

14. All levels of government in Australia have a responsibility for the health of all people in Australia, which can be fulfilled only by the provision of adequate social conditions and health services. All levels of government should ensure that public health and health care systems progress towards

reducing health inequities through a universal approach for all, with greater emphasis for disadvantaged and vulnerable groups.

15. Innovative public health policies that address health inequities are best framed around the social determinants of health (3, 28). Interventions to reduce health inequities should also take a life course perspective.
16. Ensuring that people and communities are engaged in decisions affecting their lives, health and wellbeing is fundamental to good health. This is particularly the case for socially and economically excluded populations who are also most likely to have been politically excluded as well. The provision of accurate information and engagement of civil society to promote these objectives are integral to achieving this outcome.
17. Environmental, health and equity agendas must be addressed together through coherent policy at global, national and local levels, recognising that climate stabilisation, eradication of poverty, and health gains are inextricably linked (29).
18. The Health in All Policies (HiAP) approach is a key strategy for ensuring that health and well being are core considerations in policy development in all sectors (30).

The PHAA recommends:

19. Reduction in social and health inequity nationally as a result of government policy directives should be recognised as a key measure of our progress as a society.
20. The Australian Government, in collaboration with the states, territories and local governments, should outline a comprehensive national cross-portfolio and cross-government framework to reduce health inequities. This policy framework should include the following policy objectives:

Reduce social inequity by:

- Ensuring that the equal distribution of the social determinants of health is a priority of policies in all sectors;
- Adopting a Health in All Policies (HiAP) approach (30) at all levels of government;
- Recognising that economic inequality is a major health determinant; and
- Undertaking Health Inequity Impact Assessment of significant public policies to eliminate (or reduce) any inequitable impacts and/or to increase equity of impacts and outcomes.

Ameliorate adverse effects of social disadvantage on health by:

- Investing in strategies and programs to support the perinatal period and the early years of life; and
- Working with local communities and governments in disadvantaged regions to increase environmental and social infrastructure and thereby improve health and wellbeing.

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

- Enabling the participation of disadvantage groups across the continuum of health care including prevention;
- Providing comprehensive Primary Health Care; and

- Providing a high quality, accessible, culturally competent and safe publicly funded health system that includes access to essential medicines and holistic care, particularly for vulnerable, excluded or disadvantaged population groups.

21. This policy framework should be supported by:
    - Accurate monitoring of health inequalities;
    - Routine reporting on health inequalities that are considered to be inequitable;
    - Assessment of the impacts of policy including systematic differences in the distribution of the determinants of health; and
    - Increased research funding directed at:
        - examining the relationship between the distribution of social, economic, and environmental resources and health inequities;
        - exploring the impact of cultural, social, and political inclusion on the health of marginalised populations; and
        - systematic evaluation of the impact of policies and interventions designed to reduce inequities.

    The policy framework should be linked to or incorporated into the National Health Performance Framework endorsed by the Australian Health Ministers' Conference (AHMC).

22. The Australian Government should work towards correcting inequities in health at the regional and global levels, through policies in all sectors (including foreign policy, development policy, official development assistance and trade policy). This requires both an adequate foreign aid budget and ongoing commitment to work towards the United Nations Millennium Development Goals and the recommendations from the World Health Organization's Commission on Social Determinants of Health (19).

The PHAA (including the National Office, branches and special interest groups) resolves to undertake the following actions:

23. Work within the health system, with other health bodies, and with organisations in other sectors to build a movement committed to reducing health inequities.

24. Promote the awareness of health (and other) professionals and policy actors and engage in dialogue on reducing or eliminating inequalities in the distribution of health services and programs, and other social goods, resources and burdens.

25. Work with the World Federation of Public Health Associations and other global, regional and national organisations to advocate for global action to reduce health inequities.

26. Seek commitment from Australian governments to develop the health inequities framework described above by:
    - engaging politicians as champions for increasing the equality of distribution of the determinants of health;
    - seeking cross-party support for a parliamentary committee to increase the equality of distribution of the determinants of health across all population groups in Australia; and
    - analysing the health inequity impact of the platforms of the major parties in the lead-up to elections.

27. Advocate for the full implementation and evaluation of the Australian Government's social inclusion agenda, 'A Stronger, Fairer Australia', to reduce social disadvantage (31).

28. Promote awareness of social determinants of health among public sector organisations such as local government bodies which have an opportunity to influence these.

29. Advocate for the development of Australian Government policies and programs and evaluation processes to measure progress in line with the World Health Organization's Commission on Social Determinants of Health (3), the United Nations Millennium Development Goals (32) and the Human Rights Commission.

30. Advocate for the implementation of, and effective evaluation of progress against, the Australian Government's six key targets for 'Closing the Gap on Indigenous Disadvantage', in order to address social determinants of health (33).

31. Advocate for the inclusion of health inequities and social determinants of health in university courses, including:

    - that university undergraduate health professional and postgraduate public health courses and leadership programs make the study of human rights, health inequity and the political economy of health a core part of their curriculum;
    - that professional undergraduate training supports a psychosocial approach to relationships and patient-centred care rather the ' medical model'; and
    - endeavour to have the distribution of the social determinants of health placed on the agenda of other degrees and courses outside the traditional health sphere so students may develop an appreciation of the potential impacts their chosen field has on population health – for instance, town planning, civil engineering, architecture, Master of Business Administration (corporate social responsibility).

32. Advocate for research into the social determinants of health and health equity, including:

- research on the distribution of and access to the social determinants of health for priority populations across the life course in line with National Research Priorities including 'A Healthy Start to Life' and 'Ageing Well, Ageing Productively' (11);
- research into, and the development of, governance structures that provide for vulnerable groups to engage in policy and program development to correct health inequities; and
- research on interventions to reduce health inequities, including research focused on the analysis and development of economic and social policies that reduce health inequities, and how innovative public sector administrative and budgeting structures can contribute to improved inter-sectoral collaboration (34).

ADOPTED 2001, REVISED AND RE-ENDORSED 2002, 2006, 2009 and 2012

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