

Research Summary

Key influences on health inequalities



VicHealth

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VicHealth has identified tackling health inequalities as an overarching theme of our *Strategic Priorities 2006–2009*. To do this, VicHealth focuses on three objectives: 1) Reduce health inequalities experienced by those most affected by social and economic inequality; 2) Improve knowledge in order to understand and respond to health inequalities; and 3) Influence social and economic policy that has an effect on health inequalities.

VicHealth seeks to improve the health of all Victorians but targets activities towards: disadvantaged areas, lower socioeconomic groups, Indigenous and refugee communities, people with disabilities, and disadvantaged children and young people.

This document presents some recent research related to health inequalities with a focus on:

1. The key influences on health, including access to work, education, housing and community infrastructure
2. How these influences impact on health
3. How access to these influences is inequitable.

Data has been drawn from evidence reviews and independent studies. This is one of two research summaries on health inequalities. The other summary has a focus on the burden of disease due to health inequalities.

Concepts

Health inequalities are differences in health status (such as rates of illness and death or self-rated health) that result from social, economic and geographic influences that are avoidable, unfair and unnecessary (Victorian Health Promotion Foundation 2005).

Health inequalities are complex, but can be explained largely by unequal access to material resources necessary for health, such as good housing, adequate income and healthy food. As well as having a direct impact on health, these may also result in psychological and social conditions which are damaging to health. For example, low income and unemployment can lead to social isolation and exclusion, both of which have been found to influence health. In turn, these conditions can influence whether people adopt healthy behaviours. For example, a perception that they are being treated unfairly may undermine people's trust in others and in institutions, and hence their capacity to form the social connections understood to be important for good mental health (Victorian Health Promotion Foundation 2005).

This research summary focuses on the evidence linking access to the socioeconomic resources and health inequalities.

The following social and economic resources can reduce inequalities in health:

- work and meaningful employment
- education
- adequate housing
- healthy foods
- accessible health and community service infrastructure
- safety and justice
- urban planning that promotes social mix and transport.

The pathways that contribute to health inequalities affecting Indigenous Australians are complex and unique. In addition to the above they include the influences of colonisation, racism and loss of land (Carson et al 2007; Pulver et al 2007).

Emerging research from the United States suggests overall health in middle and late adulthood are shaped by socioeconomic conditions experienced during childhood, and from the accumulation of instances of disadvantage over an individual's lifetime (Turrell, et al 2007).

Access to social and economic resources and their impact on health

Employment

Secure and satisfactory employment offers financial independence, a sense of control, self-confidence and social contact (Stanwick et al 2006). People who lack job security or who are unemployed consistently report the lowest levels of self-rated health and subjective wellbeing (Cummins et al 2006).

Working conditions that do not provide stability of employment (such as highly casualised employment) are associated with adverse health outcomes and can be as dangerous as traditional unemployment for workers' health (Benach & Muntaner 2007).

International evidence shows that an imbalance between effort and reward in the workplace is a risk factor for alcohol dependence in men (LaMontagne et al 2006).

Unemployment, insecure employment and unfavourable working conditions have all been associated with low self-esteem, feelings of depression and mental health problems in young people (Morrell et al 1998).

There is an association between unemployment and a range of health concerns including low self-rated health, cardiovascular disease, and drug and alcohol abuse (Australian Institute of Health and Welfare 2007).

For men, working conditions including extreme and moderate job pressure and excessive working hours are associated with smoking. High psychological demand at work is also associated with smoking intensity (Ostry et al 2006). Job stress acts as a barrier for workers who want to stop smoking (LaMontagne et al 2006).

For women, physically demanding work is associated with smoking (Ostry et al 2006). Also, women in fixed-term and casual jobs have much higher levels of work stress and are also more likely to report being subject to unwanted sexual advances at work (LaMontagne, Ostry et al. 2006). Unwanted sexual advances have been strongly linked with poorer health outcomes (Timmerman 2004; Victorian Health Promotion Foundation 2006).

Parents who lack job security and control over their work are much more likely to suffer psychological distress than workers in better quality jobs and are also more likely to report behavioural and emotional problems in their children (Alexander & Baxter 2005).

Access to employment

People with limited socioeconomic resources (such as education) are more likely to be employed in jobs that lack security (Curtain 2005; Bill et al 2007).

In 2004–05, the unemployment rate (12.9%) for Aboriginal and Torres Strait Islanders was three times the rate for non-Indigenous people (4.4%) (Steering Committee for the Review of Government Service Provision 2007).

There is an unemployment rate of 8.6% for people with a disability compared with 5% for non-disabled people (Australian Bureau of Statistics 2004). Within the Australian Public Service, the proportion of employees with a disability declined from 5.3% in 1992 to 3.6% in 2003 (Howe 2007).

In WA, researchers found 'that there is a segmented labour market where racially and culturally visible migrants, especially those from refugee backgrounds, are allocated the lowest jobs regardless of their human capital (formal qualifications, skills and experience)' (Colic-Peisker & Tilbury 2007).

Research collated by the Commonwealth Parliamentary Library found that people from North Africa, the Middle East and from Vietnam 'have rates of unemployment much higher than other overseas-born persons'. At June 2005, unemployment rates were 12.1% for people from North Africa and the Middle East and 11% for people from Vietnam. This compared to a rate of 5.3% for all overseas-born, and 6.2% for those born in all non-English speaking countries (Anthony 2006).

After some settlement in Australia (three and a half years), 47% of migrants from Anglo-Celtic backgrounds originating from the UK and America were using their qualifications in taking up employment opportunities, compared with 31% of migrants from non-English speaking backgrounds (Ho & Alcorso 2004).

Lebanese, North African and Vietnamese migrants have lower household income, employment status and housing conditions than 'white' new arrivals from Europe, Great Britain and New Zealand with the same length of settlement time in Australia (Borooh & Mangan 2007).

In 2007, 9.5% of Australian children aged 0–17 years live in households without an employed parent (UNICEF 2007).

Education

International and Australian research supports a link between less education and poorer health (Stanwick et al 2006; Turrell et al 2006; Laplagne et al 2007). Education can impact on health by increasing knowledge about health, such as awareness of harmful behaviours. Education can also lead to better quality jobs, and this may be a protective factor against poor health. Education also contributes to increasing self-esteem and self-worth (Stanwick et al 2006; Australian Institute of Health and Welfare 2007). Emerging evidence suggests that life long learning plays a contributing factor in preventing the onset of diseases of ageing such as Alzheimer's (Youssef & Addae 2002).

Learning environments can help people interact with others and develop networks which have positive impacts on health and wellbeing (Stanwick et al 2006).

People with lower educational attainment rate their own health more poorly and report a number of illnesses more often than those with a bachelor degree or higher (Turrell et al 2006).

People with degree qualifications are more likely to have better physical and mental health than people with Year 11 or lower qualifications (Stanwick et al 2006).

Better education leads to a better overall self-assessed health status, which, in turn, leads to higher labour force participation. In particular, having a degree or a higher qualification strongly improves labour force participation (Laplagne et al 2007).

Access to education

Education rates for Indigenous students have steadily increased over the past decade. However:

- About 40.1% of Indigenous students finished a Year 12 education, compared with 75.9% of non-Indigenous students.
- Indigenous young people are approximately 15 times less likely to have a bachelor degree or above and around 23% less likely to have a certificate or diploma (Australian Institute of Health and Welfare 2007).

Female school completers from a low socioeconomic background are less likely to go on to university than boys from this background (Nelms 2007).

Australian data indicate that those with the lowest rates of participation in further learning (formal or informal) are:

- labourers (18%)
- people working in manufacturing (14%)
- people working in the retail industry (11%)
- those without non-school qualifications (34%); and
- people earning the lowest weekly income (Australian Bureau of Statistics 2007a).

The main reasons for those unable to participate in learning was due to being too busy (44%) or unable to afford training (18%) (Australian Bureau of Statistics 2007a).

In 2003, 16.4% of Australian children reported having less than six educational possessions, and 4.9% reported less than 10 books in the home (UNICEF 2007).

In 2007, 44% of people with a disability (compared with 29% of those without), had left school at Year 10 or below (Howe 2007).

Income and wealth

Low incomes reduce people's access to the resources necessary to maintain and improve health (Turrell et al 2006).

People on low incomes consistently rate their wellbeing as the lowest in a national survey reviewing Australians' levels of wellbeing (Cummins et al 2006).

Children from families experiencing economic hardship may be at an increased risk of injury because of greater exposure to physical

hazards in the home such as the use of old and faulty equipment, electrical faults, lack of smoke detectors and use of old and second-hand products (Blakemore 2007).

The risk of premature death is significantly higher for children from disadvantaged families, when measured by length of time on a pension or benefit and low income. For example, low-income families have an excess child death rate of 49.6% (Yu 2007).

Access to income and wealth

In 2003–04, 49% of one-parent families with children under 15 had both low income and low wealth, compared with 11% of couple families with children of the same age (Australian Bureau of Statistics 2007b).

In 2004–05, average weekly household income for Indigenous Australians was \$340, compared to \$618 for non-Indigenous households (Steering Committee for the Review of Government Service Provision 2007).

Earnings gaps for recent arrivals persist despite length of settlement in Australia (Teicher et al 2002).

61% of Australian household wealth is owned by the richest 20% of households while the bottom 20% own just 1% of Australia's household wealth (Australian Bureau of Statistics 2007f).

11.6% of Australian children aged 0–17 years live in poverty, according to the measure used by the OECD with developed countries (UNICEF 2007).

Housing

Housing has a range of impacts on health. Housing insecurity and unaffordability, overcrowding, and inadequate housing – including uninsulated housing – are associated with inequalities in health (Waters 2001; Howden-Chapman 2004; Australian Housing and Urban Research Institute 2007b).

People living in rented accommodation are significantly more likely to report fair or poor health, to be smokers, to have recently visited a doctor, or to have a higher number of serious health conditions than home owners (Waters 2001).

Overcrowding can result in severe health and wellbeing problems (Waters 2001), as it places excessive demand on bathroom, kitchen and laundry facilities and can lead to the spread of infectious diseases.

In a New Zealand study of people of low socioeconomic status, those in insulated houses were half as likely to report fair or poor health, have respiratory problems or colds/flu symptoms. Children were half as likely to have days off school and adults reported fewer days off work due to sickness (Howden-Chapman et al 2007).

Access to housing

Across Australia in 2004–05, 25.4% of Indigenous people aged 18 years and over lived in home owner/purchaser households. In Victoria, this figure is just under 40% (Steering Committee for the Review of Government Service Provision 2007).

Around two-thirds of private rental low-income households are single-person households. There is also an over-representation of overseas-born residents in private rental low-income households (Australian Housing and Urban Research Institute 2007b).

Of the 57,160 housing transactions in 2003, only 1130, or 2%, would be affordable for someone on an average income. This compares with 13.5% in 1996. In 2003, 27% of affordable transactions in houses were in 'close proximity' (eight kilometres) to an identified principal activity centre. In 1996, that figure was 42% (Khadem 2007).

Healthy food

Healthy eating is a key building block to good health. Nutritious food contributes to physical and mental wellbeing throughout a person's life. Healthy eating includes the cultural and social significance of growing, cooking and sharing food (Victorian Health Promotion Foundation 2007). *Broader economic, social and environmental factors such as globalisation, trade agreements, taxes levied on foods, transport, urban development and food policies may determine the availability, quality and price of food, and subsequently influence food choices* (Branca 2006).

The risk of obesity is 20–40% higher in women who have low incomes and are experiencing food insecurity (ie. run out of food and are unable to buy more). This is consistently observable across Australia as well as the United States and Europe (Burns 2004).

Disadvantaged communities in Melbourne have up to 2.5 times the exposure to fast food outlets. Men and women living in these low socioeconomic suburbs are likely to be up to 3 kg heavier than if they lived in one of the most advantaged areas (King et al 2006).

It is estimated that dietary factors account for 7–20% of the total burden of chronic disease in Australia (Victorian Health Promotion Foundation 2007).

Access to healthy food

Almost 60,000 Australians in low-income families go without meals or are food insecure (Victorian Health Promotion Foundation 2007).

In 2005, almost one in 20 Victorians had run out of food at least once in the previous 12 months and was unable to afford more (Victorian Health Promotion Foundation 2007). In 2006, almost

6% of children were from households where a parent reported having run out of food and being unable to buy more at some time in the previous 12 months (Department of Human Services 2006).

Health, social and community infrastructure

Access to health, social and community services builds capacity for individuals to maintain good health and avoid illness. Access to health services ensures more timely treatment and prevention (Australian Institute of Health and Welfare 2007; Rainham 2007; Tobias & Yeh 2007). *Participation in organised sport, arts and community activities can improve health and physical and mental wellbeing, reduce emotional and behavioural difficulties, improve confidence and self-esteem, improve learning performance, prevent smoking and illicit drug use, reduce crime and improve social cohesion* (Steering Committee for the Review of Government Service Provision 2007). *Sport and active recreation improves physical health, has been linked to increased self-esteem, better development of life skills and decreased risk of risky behaviours, and improves productivity and reduces injury risks and other health costs* (Victorian Health Promotion Foundation 2007).

Patients in low socioeconomic areas are less likely to receive longer GP consultations than patients in more advantaged areas. The rate of longer consultations increases by almost 4% with each step up in socioeconomic status (Furler et al 2002). Longer consultations have been found to be associated with better quality of care.

In New Zealand, the health of people from Anglo-Celtic backgrounds is estimated to be 36–44% better due to their access to health services (Tobias & Yeh 2007).

The rate of hospitalisation for refugees is lower than the average for Victorians, due in part to refugees not knowing how to access the system in the first few years after arrival (Correa-Velez et al 2007).

Inadequate post-arrival health care for refugees means some, including children, go untreated for conditions which may have serious health consequences. It also means that they are not offered routine preventive health care such as immunisations (Royal Australian College of Physicians 2007).

In a Victorian study of 126 participants of recent African arrivals in Australia, it was found 17% had not seen a GP since arriving in Australia and 26% had had health problems for which they had not sought advice (Neale et al 2007).

People with psychiatric disabilities have less access to some procedures for circulatory disease, even in a universal health care system that is free at the point of delivery (Kisely et al 2007).

Between 1995 and 2004/05 there was a statistically significant decrease in the proportion of Indigenous people in non-remote areas who were engaged in moderate or high levels of exercise (from 30.3% to 24.3%) (Steering Committee for the Review of Government Service Provision 2007).

Within organised sport, the proportion of the population involved as players and non-players was similar for Australian-born (31.3%) and for migrants from mainly English speaking countries (26.1%), yet significantly lower for migrants from non-English speaking countries (12.6%) (Australian Bureau of Statistics 2007g).

Compared to participation in sport and physical activity by all Australian adults (62.4%), participation was lowest for migrants from Southern and Eastern Europe (42.5%) and those from North African and Middle Eastern background (31.2%). Participation levels amongst women from North Africa and the Middle East were only 19.5% (Cortis et al 2007).

Children's participation (for ages 5–14 years) in organised sport is much lower for children born in non-English speaking countries (30%) compared with children born in mainly English-speaking countries (38%) or in Australia (41%). 56.1% of children from non-English speaking countries were involved in after-school sports and cultural activity, compared with 72.7% amongst migrants from mainly English countries and 73.9% amongst Australian-born children (Australian Bureau of Statistics 2006a).

Compared with the corresponding figures for 1998, the participation rates in sports and physical activity recorded in 2003 for persons with a disability were lower for almost all combinations of disability status and sex. There was a drop of 3% (from 27.6% to 24.6%) in the overall participation rate for persons with a disability. Other significant falls in participation rate included the overall rate for males with a disability (by 4% from 32.2% to 28.2%), the rate for males with a mild core activity limitation (by 19.7% from 33.7% to 27.1%), and the rate for females with a moderate core activity limitation (by 24.2% from 21.6% to 16.3%) (Australian Bureau of Statistics 2007c).

Safety and justice

Perceptions of a lack of safety contribute to stress and levels of fear in individuals and reduce levels of trust and social connection. This can lead to limited access to the health and community services necessary to maintain health and wellbeing (Wiseman et al 2006). Contact with the police can lead to fear and mistrust when people feel they are being singled out for treatment (Gifford 2007).

Safety can be compromised in the home and this is especially the case for women and children. Three quarters of all assaults against women occur in the home. In 71% of assaults against women, the assailant is a man known to them (Australian Bureau of Statistics 2006).

88% of Australians who feel safe or very safe at home at night rate their health as good to excellent, compared with only 5.5% by those who felt unsafe or very unsafe (Australian Bureau of Statistics 2007d).

Women who have been exposed to violence have a greater risk of developing a range of health problems (WHO 2000). Intimate partner violence alone contributes 9% to the disease burden in Victorian women aged 15–44 years, making it the largest known contributor to preventable disease burden in this group (VicHealth 2004).

Access to safety and justice

In 2002, Victorian Koories were more than three times more likely to have reported being a victim of crime in the past 12 months than non-Indigenous Victorians (Australian Bureau of Statistics 2004b).

One in three Victorian women has experienced physical violence since the age of 15 (Australian Bureau of Statistics 2006b).

Although family violence occurs in all social groups, Indigenous women and children are particularly affected (Mouzos & Mikkai 2004; Victorian Indigenous Family Violence Task Force 2003).

When apprehended by police, Indigenous people are half as likely to be given a caution compared with non-Indigenous people (Department of Justice 2005).

Between 2000/01 and 2004/05, Victorian Indigenous people were slightly more likely to be sentenced to prison than community-based orders, and 12% less likely to be released on parole when in prison (Department of Justice 2006).

In 2003/04, Indigenous youth “were nearly three times less likely to be cautioned when processed by police” and more likely to be immediately charged than non-Indigenous youth (Department of Justice 2006).

Recent longitudinal research with newly arrived young people from a range of countries found 56% of study participants from Sudanese backgrounds were approached by police for questioning, compared with only 30.6% for the study sample as a whole (Gifford 2007).

Recent trends in the prison population show increases in the numbers of females, Indigenous people, those with mental health concerns, and prisoners with complex health-related conditions, including multiple illicit substance use, alcohol problems and communicable diseases (Brouwer 2006).

Urban planning and transport

There is consistent evidence that place has an independent effect on health (King et al 2006; Turrell et al 2007). *In Australia, concentrated pockets of people on low incomes living in the one area have emerged in recent decades* (Klein 2004). *Experts have attributed this to various factors including economic rationalisation, restructuring and closure of manufacturing industries, and public housing planning policies* (Klein 2004). *Such concentration appears to compound negative influences on health (eg poor educational attainment, poor working conditions) and is associated with higher rates of health-damaging behaviours and health attitudes* (Kavanagh et al 2007). *Transport is important to health in a number of ways. Increased public transport reduces greenhouse gas emissions and other air pollutants, provides access to health and social services for community residents, and improves mental health through improving opportunities to connect with other community members* (Public Transport Users Association Victoria 2007).

A recent study found that 44.2% of people in housing stress said they felt trapped in an area with poor job prospects, while 42.4% said their children had missed out on school activities such as sports and excursions and 39% said their children had to go without adequate health and dental care (Burke 2007).

In Victoria, concentration of low-income private renters in any one location is relatively low: No suburbs have more than 27% of households that are low-income private rental. However, higher concentrations are apparent in the northern suburbs (Reservoir and Thornbury) and in the outer south-east (Frankston and Dandenong) (Australian Housing and Urban Research Institute 2007a).

'Scattering' of poverty, however, can also have negative health implications as those living on low incomes in areas of affluence may feel a sense of shame (Stanley et al 2007).

Child pedestrian injuries are linked to living in areas of higher disadvantage, high-density housing, streets with heavy traffic flow and limited access to safe playgrounds (Blakemore 2007).

Access to transport

In 2003, 275,700 people living in Victoria with a disability (ie. 30% of all Victorians with a disability) had some difficulty with public transport access (Australian Bureau of Statistics 2004).

9.3% of unemployed Victorians have difficulty with transport when getting to the places they need, compared with 1.6% of full-time employed Victorians. Similarly, 7.6% of Victorians earning the lowest incomes had transport difficulties compared with 1.7% of those at the highest income level (Australian Bureau of Statistics 2007e).

19.5% of public housing tenants had difficulty with transport compared with only 2.75% of home-owners and 3.4% of private renters (Australian Bureau of Statistics 2007e).

Key determinants contributing to Aboriginal health inequalities

Poorer health and wellbeing outcomes for Aboriginal people are the result of a complex set of interacting factors. In addition to the socioeconomic factors discussed above, these include the impacts of colonisation and the subsequent disadvantage experienced over more than two centuries (Altman et al 2003; Hetzel et al 2004; Carson et al 2007; Pulver et al 2007).

Ethnic/race based discrimination

Racism is a key determinant of Aboriginal health inequalities, with increased exposure to racism associated with worse mental health outcomes. In addition, health-related behaviours (such as smoking and excessive drinking) are significantly associated with racism (Paradies 2007).

Aboriginal people who reported negative racially based treatment were more likely to have poor health on measures of mental health, physical health and self-rated health (Larson et al 2007).

Connection with land

Land is an essential part of an Aboriginal view of health, with personal identity considered inseparable from place. Interaction with country is understood to enable an adult to develop mastery and control over their lived environment (Burgess & Morrison 2007).

While Victoria does not have a land claims regime as such, of the 227,416 square kilometres of land in Victoria, 100 km² are Indigenous owned or controlled, equating to 0.04% of land ownership in the state (Steering Committee for the Review of Government Service Provision 2007).

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