VicHealth

VicHealth position statement on
Health Inequalities

1 Preamble

While working to improve the health of all Victorians, VicHealth is committed to reducing inequalities in health. Health inequalities are disparities in health status (such as rates of illness and death or self-rated health) that result from social and economic influences that are avoidable and unnecessary.

VicHealth's *Strategic Directions 2003–2006* identifies addressing health inequalities as a key activity, stating that we seek to:

- increase the knowledge base about social and economic factors that cause poor health and identify effective ways for reducing inequalities; and
- establish partnerships with others working with and representing disadvantaged groups to reduce social and health inequalities.

This position statement has been developed on the basis of a more detailed and fully referenced background paper available at www.vichealth.vic.gov.au/inequalities

2 The nature and causes of health inequalities

VicHealth notes that:

2.1 There are marked inequalities in health between groups in Victoria, a pattern found consistently across societies. These inequalities exist on a range of measures (including rates of death, illness and injury; life expectancy and self-rated health) as well as in factors known to influence health (such as smoking and high blood pressure; the use of health and illness prevention services; and health knowledge, attitudes and behaviours).[1–17]

2.2 Socioeconomic position is a major determinant of health inequalities. Those experiencing socioeconomic disadvantage generally have poorer health than their more advantaged counterparts.[2,3,8,15,18] The most disadvantaged have the poorest health, with health status generally improving along the social gradient.[19]

2.3 While a range of factors has been found to be associated with inequalities, the most significant and persistent include level of education, occupation, income, employment status and area of residence,[3,7–10,12–14,20,21] disability,[22–25] refugee background[11,17,26–29] and

Aboriginality.[2,14,20,30] Ethnicity and gender are also factors that may contribute to and compound health inequalities.[31–34]

2.4 Inequalities in health status between groups are directly related to social and economic inequalities.[35,36] Countries with lower levels of social and economic inequality tend to have less-marked health inequalities.[37,38]

2.5 Health inequalities are explained largely by unequal access to material resources necessary for health, such as good housing, adequate income and healthy food.[37] As well as having a direct impact on health, these may also result in psychological and social conditions which are health damaging.[37,39,40] For example, low income and unemployment can lead to social isolation and exclusion, both of which have been found to influence health.[41,42] 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.[43–45]

2.6 Inequalities in health have been found between geographic areas.[2,8,9] This is due both to people with similar health status living in the same areas and to local environments that do not support good health (e.g. because they lack accessible, cheap and healthy food, safe streets or opportunities for meaningful social participation).[46]

2.7 Health inequalities are most marked between Indigenous and non-Indigenous Australians. Aboriginal men and women have a life expectancy which is 17 years lower than the national average.[30]

2.8 People who have recently arrived as refugees also have relatively poor health status, the result of exposure to deprivation, human rights abuses, conflict and violence in their countries of origin and asylum and the stresses involved in establishing life in a new country.[29] A range of health problems (e.g. communicable diseases, nutritional deficiencies, mental health problems) are relatively prevalent in refugee communities.[11,17,26–29] Many refugees settling in Australia come from countries rated by the United Nations to have among the lowest levels of human development and life expectancy in the world.[47,48]

2.9 As a group, people with disabilities tend to report poorer perceived health status, with ratings of health declining the greater the degree of disability.[1,2] Some forms of disability have been found to be associated with lower life expectancy.[22–25] People with disabilities also have demonstrably limited access to the social and economic resources required for health. They are less likely than those in the general population to be in the workforce (53% compared with 81%) and more likely to be unemployed or to be in receipt of a low income.[49] People with disabilities also experience barriers to accessing health and support services.[22,24,50,51]

2.10 Health inequalities are the result of the cumulative effect of exposures over a lifetime.[52] However, childhood and adolescence are particularly

crucial times because experience in early life influences later behaviour and physical and mental health.[35–37,52–54]

2.11 While low socioeconomic position causes poor health (rather than the reverse), poor health can increase the likelihood of a person becoming disadvantaged. This contributes to a cycle of poor health and disadvantage which may persist across generations.[52]

3 Issues in addressing health inequalities

VicHealth acknowledges that:

3.1 Some health inequalities are unavoidable (e.g. some health problems associated with ageing). However, most can be avoided.

3.2 Strategies and approaches to address health inequalities are not well developed and recognised.

3.3 There are four levels at which health inequalities can be addressed. These are:

- taking steps to reduce inequalities in power, prestige, income and wealth;
- reducing the effect of health on socioeconomic position (e.g. by providing benefits and supports to people in poor health);
- reducing the risk of negative impacts of social and economic disadvantage on health (e.g. through the provision of good public housing for low income earners); and
- reducing the health effects of low socioeconomic status (e.g. through providing good quality and appropriate primary care).[55]

3.4 A challenge for health promotion is to determine a balance between focusing on the most disadvantaged (who indisputably have the worst health) and population-wide approaches. Population-wide approaches address health issues across the social gradient. Where all things are equal, they should have the greatest impact on health problems among the most disadvantaged since this group has the highest risk at the outset.[37] However, many health promotion interventions, particularly those seeking to improve health through individual behaviour change, can have the effect of increasing inequalities in health. This is because these approaches are more effective among people of higher socioeconomic status.[56,57]

3.5 Addressing socioeconomic disadvantage and health inequalities is a goal of the Victorian Government[58,59] and is one shared by a number of governments, including those of Britain, Sweden, Canada, Australia, New Zealand and the Netherlands.[56,60,61]

4 VicHealth principles

VicHealth adopts the WHO goal for health equity that is concerned with 'creating equal opportunities for health and bringing health differentials down to the lowest level possible'. In particular, VicHealth acknowledges that:

4.1 Societies that strive to enable all individuals to participate fully in social, economic and cultural life are more likely to have healthy citizens than societies that allow individuals to be excluded, marginalised and deprived.

4.2 Equitable access to social, economic and environmental conditions that sustain and promote health is a fundamental human right. In Victoria, significant differentials in these conditions for health and health status exist between population subgroups.

4.3 Health promotion efforts should alleviate and not exacerbate health inequalities. The aim of health promotion should not be to eliminate all health inequalities, but rather to reduce or eliminate those that result from factors that are potentially avoidable and unfair and which result in significant disease burden among disadvantaged groups.

4.4 Interventions to address health inequalities should recognise that the relationship between social and economic inequalities and health inequalities is complex, and results from the influence of material, psychosocial and behavioural factors over a lifetime and across generations.

4.5 Policy responses need to address multiple leverage points to be effective in reducing health inequalities (see paragraph 3.3).

4.6 Policy responses need to look at points of intervention that address both the influence of adverse socioeconomic factors on health and the influence of ill-health on socioeconomic status.

4.7 Addressing the root causes of socioeconomic inequality is difficult but may be the most effective way to reduce population health inequalities.

4.8 Success in promoting better health is more likely to be achieved through ensuring that improvements in the psychosocial environment are accompanied by improvements in the material and economic environment.

4.9 To reduce health inequalities health promotion approaches must work with both people and the places in which they live their lives.

4.10 Action on the social and economic determinants of health requires greater engagement with a range of sectors, including social services, environment and infrastructure, housing, education and employment.

4.11 Health promotion interventions are most likely to be effective in reducing future inequalities in health when they relate to present and future parents, especially mothers, and children.

4.12 Health promotion interventions to address inequalities need to respond appropriately to culturally diverse and Indigenous populations and take account of the role of gender in contributing to health, social and economic inequality.

4.13 Disadvantaged communities need to be part of the decision-making process at the state and local level if we are to effectively address health inequalities.

5 VicHealth will undertake to:

5.1 Build knowledge to improve capacity across sectors to address health inequalities

5.1.1 Identify interventions that will reduce inequalities in the social and economic determinants of health, health behaviours and health status between subgroups of the Victorian population.

5.1.2 Advocate and support the development of systems for monitoring the extent and distribution of health inequalities in Victoria.

5.1.3 Prioritise capacity building for public health research addressing health inequalities, in particular inequalities affecting low socioeconomic, Indigenous and refugee communities and people with disabilities.

5.2 Engage in advocacy to reduce health inequalities

5.2.1 Engage in advocacy to increase understanding of the relationship between social and economic inequalities and health inequalities and seek to influence broader social and economic policy that will have an effect on health inequalities.

5.2.2 Work in partnership with key agencies and individuals working with and representing disadvantaged groups to reduce health, social and economic inequalities.

5.2.3 Disseminate information to public health professionals and communities to improve skills, knowledge and practice in reducing health inequalities.

5.3 Develop projects and programs to address health inequalities

5.3.1 Continue to invest in area-based programs in relatively disadvantaged socioeconomic areas and work with local governments in addressing health inequalities.

5.3.2 Continue to invest in programs and projects that engage the participation of population groups particularly affected by health inequalities, including those of low socioeconomic status, Indigenous and refugee communities and people with disabilities.

5.3.3 Develop projects and programs that seek to maintain and extend the implementation of health promoting policies across sectors that respond to the needs of the most disadvantaged.

5.3.4 Explore opportunities to adopt a life-course perspective on health inequalities and identify the best options for investing in interventions targeted to people of different ages within VicHealth-funded programs.

5.4 Explore operational options for reducing health inequalities

5.4.1 Continue to strengthen linkages between VicHealth-funded research and its programs to ensure they are based on sound evidence and to build an evidence base for both policy advocacy and workforce development focusing on addressing health inequalities.

5.4.2 Ensure that, where possible, VicHealth-funded programs, grant-making processes and activities address health inequalities through a range of strategies and reduce, rather than increase, health inequalities.

5.4.3 Strengthen and refine systems for assessing and monitoring the reach of VicHealth-funded programs and their impact on groups particularly affected by health inequalities.

5.4.4 Strengthen processes for ensuring that groups particularly affected by health inequalities are actively involved in decision-making in VicHealth-funded activity.

5.4.5 Strengthen the capacity of the VicHealth workforce to understand and address health inequality.

5.4.6 Develop documentation to guide and monitor the implementation of this policy.

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