UNSW
THE UNIVERSITY OF NEW SOUTH WALES

Centre for Primary Health Care and Equity

Current thinking on the role of health systems in reducing health inequity

health is an outcome of:

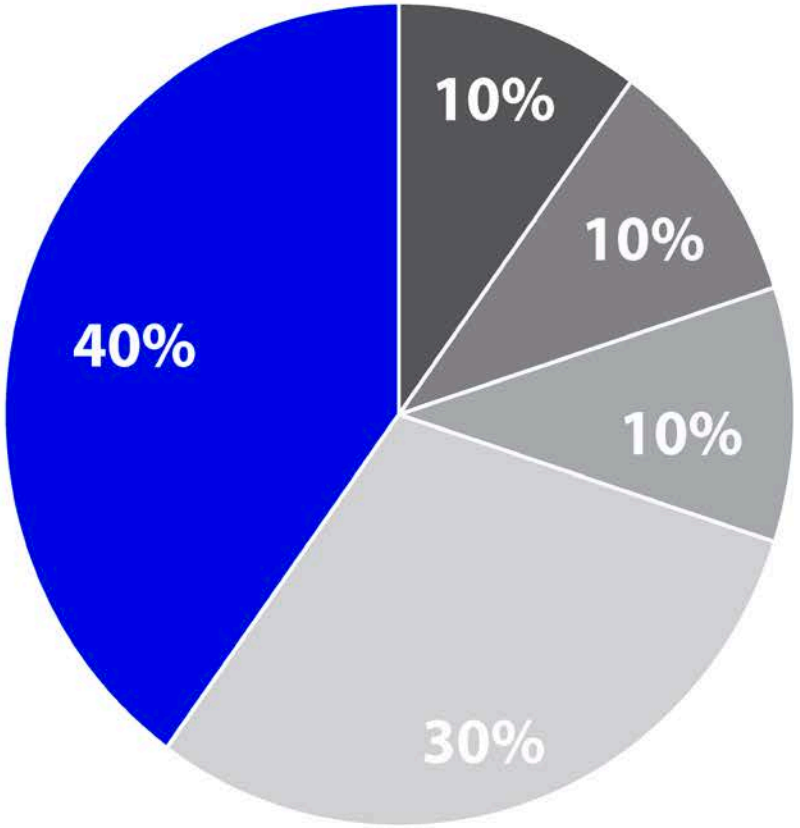
- naturally occurring phenomena
- human intent
  - personal choices
  - social choices
    - about what are considered to be social determinants of health;
    - about their distribution (who should get what and how much); and
    - about the preferred distributive mechanisms

The Social Determinants of Health

To address health inequalities, you must address social and economic inequities.

ocial & Economic Factors

- **Education**
- **Employment**
- **Income**
- **Family & Social Support**
- **Community Safety**



and other, non-material resources

- freedom from
    - humiliating disrespect
    - stigma
    - indignity
    - denigrating social status
    - stereotyping

and rights and capacities to

- exercise personal power (autonomy and agency);
- exercise political power (presence and ideas).

all these determinants are distributed unequally in our society

- not because of naturally occurring, inherent characteristics of the groups;
- not because people made bad behavioural choices;

but, rather

- because people, through social organisations, decided on how resources should be distributed across society or communities.

Not all the inequalities are unfair and unjust.

distributions are decided upon and applied through

- voting preferences of populations in democracies (the majority) (citizens)
- governments and their institutions, including the health care system
- the market
- non-government sector
- civil society

and through the people who are their agents

Distinction between inequalities & inequities in health – more than semantics

Inequalities in health are a consequence of:

1. natural biological variation;
2. health damaging behaviour if freely chosen, such as participation in certain sports and pastimes;
3. the transient health advantage of one social group over another when that group is first to adopt a health promoting behaviour (as long as other groups have the means to catch up fairly soon).

Inequities in health are a consequence of unfair, unjust, avoidable social treatment

4. health damaging behaviour where the degree of choice of lifestyle is severely restricted;
5. exposure to unhealthy, stressful, living and working conditions;
6. inadequate access to essential health and other public services.
7. natural selection or health-related social mobility involving the tendency for sick people to move down the social scale. (Whitehead 1992)

and health equity is

- an outcome of the equal distribution of opportunities for health in a society and community;

plus

- a measure of having brought health differentials to the lowest levels possible through the provision of:

    - equal access to available care for equal need;
    - equal utilisation for equal need; and
    - equal quality of care for all.

Whitehead M. The concepts and principles of equity and health. Health Promotion International 1991; 6(3):217-228.

Leenan H. Equality and equity in health care. Paper presented at the WHO/Nuffield Centre for Health Service Studies meeting, Leeds, 22-26 July, 1985.

What are some inequalities in health?

Life expectancy at birth 2012

Sydney LHD

- Population average 84.1 years but females expected to live 4.7 years longer than males

SE Sydney LHD

- Population average 85.1 years but females expected to live 4 years longer than males

life expectancy at birth NSW 2001 - 2012

- gaps in life expectancy between males and females within each socioeconomic quintile declined

- gaps in life expectancy increased between:
  - males in highest and lowest quintiles from 3.2 years to 3.8 years
  - females in highest and lowest quintiles from 2.3 years to 2.9 years

- gap between Aboriginal and non-Aboriginal males in NSW in 2010-12 was 9.3 years, and between females, 8.3 years.

HealthStats NSW Life expectancy. June 2016

How are some of the social determinants of health distributed?

the distribution of socioeconomic resources and their relationship to health in our societies are much better documented

- than the distributions of non-material resources – respect; self-respect; freedom from shame; freedom from denigration, negative discrimination, stigma; and the exclusion from political power

- although these are distributed inequitably and they matter

(Cunningham, J, Paradies Y. Patterns and correlates of self-reported racial discrimination among Australian Aboriginal and Torres Strait Islander adults, 2008-9: analysis of national survey data. IJEiH 2013; 12: 47.

- three things young mothers wanted to improve their health - a park in which to play with their child; support to allow them to finish school; and a world that doesn't look down on them.

Maeckelberghe E, McKee M. Changing your health behavior: regulate or not? In: EuroHealth 2015; 21(1): 21-23.

Inequalities in the distribution of socioeconomic resources in Australia in 2015

- One in four people (23% or 4.9 million people) live in low economic resource households
- 10.9% of children live in poverty, and the numbers are growing
- the net worth of persons in low economic resource households has fallen by 3.6% while the net worth of all Australians has risen by 22.2%

- of the 13% of Australians people living in extreme, multifaceted disadvantage at any time between 2001 – 2010:
  - two thirds were women, and the proportion remaining marginalised increased;
  - 25% were Aboriginal peoples and/or Torres Strait Islanders and they were 12 times more likely (than others equally marginalised) to remain marginalised across the decade.

http://www.foodbank.com.au/default.asp?id=1,134,,115

http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features10March+Quarter+2012#introduction

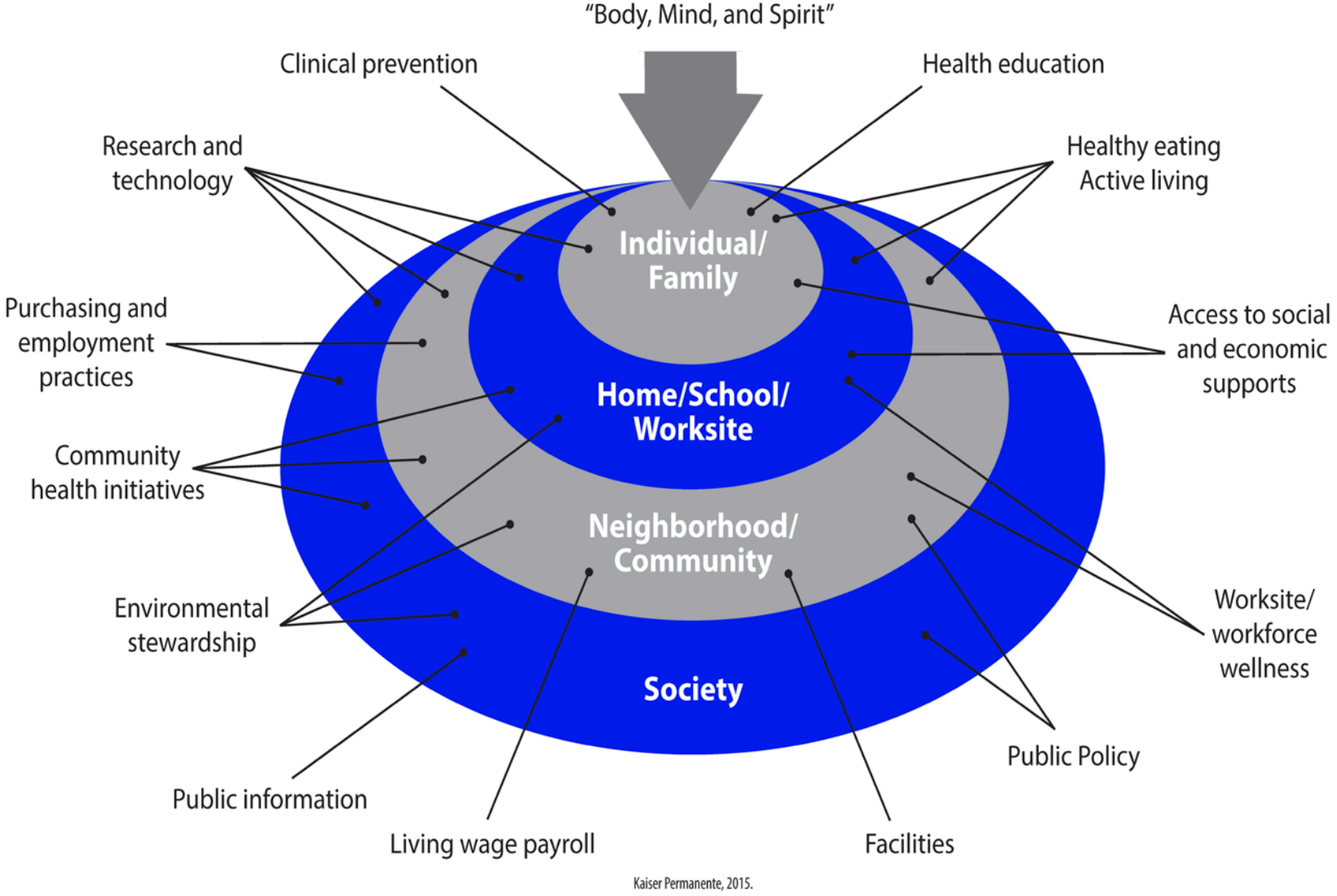
Cruwys, Berry, et al. 2013.

roles for a health system in reducing inequities in health

- there are multiple avenues through which a health system can (and must) act to reduce inequities in health;

- although as we know, the actions of any single sector can never be sufficient to bring about the wide-scale, social change that is necessary if we are to succeed in reducing inequities in health outcomes.

Asaria, M., et al. (2016). "How a universal health system reduces inequalities: lessons from England." Journal of Epidemiology and Community Health **0**: 1 - 7.


"Body, Mind, and Spirit"
Clinical prevention
Health education
Research and technology
Healthy eating
Active living
Individual/ Family
Purchasing and employment practices
Access to social and economic supports
Home/School/ Worksite
Community health initiatives
Neighborhood/ Community
Environmental stewardship
Worksite/ workforce wellness
Society
Public Policy
Public information
Living wage payroll
Facilities
Kaiser Permanente, 2015.

multiple roles for the health system in achieving health equity

as a system, we have accumulated critical knowledge of:

- inequities in the distribution of health and life expectancy;
- socially created resources, rewards & burdens that are necessary to health;
- socially created, negative attitudes to some social groups, and of the exclusion of these groups from political and social power;
- the avoidable, unfair, and unjust distributions of these determinants and the impacts on the distribution of health and life expectancy
- and some experience in reversing them.

multiple roles for the health system

- priority/commitment given to equity – or to reducing inequities
- representativeness of the membership of decision-making bodies
- decisions on the distribution of resources – financial, human, environmental; material
- what services – including population health services – are provided to populations, communities, individuals and patients
- where, to whom, and how the health care services, preventive and health promoting policies and programs, and protective measures are delivered
- sociocultural characteristics of the workforce – and how to ensure training, mentorship, and career progression
- focus of research and evaluation

recognise inequalities, identify causes, and take actions to increase equity in access to & quality of care

evidence of inequalities	potential causes?	what actions can the health system take?
differences in access to and quality of health and social services	services are not designed and delivered with sufficient knowledge of the needs of all social groups people are choosing not to attend or are not taking responsibility for their own health care : natural? laziness or lack of literacy? or lack of resources services not accessible or acceptable to all social groups services are not culturally safe – racism, or other forms of discriminatory beliefs and practices	**include** nominated representatives from **diverse social groups in decision-making** (policy, service, and program levels) Kelaher et al; SS&M, 2014) **identify why and what needs to change** (Jude Page) provide health care and social services that are app**roachable, accessible, acceptable, affordable, available, and culturally safe** (Levesque, Harris, Russell. 2013) [people come & quality improves]: cancer screening; antenatal care; health assessments] conduct/ participate in dialogues to **overcome 'fish don't see water'** partner with Aboriginal Medical Services partner with community organisations Bloss: in Hofrichter & Bhatia. 2010. Bhatia et al. in Hofrichter & Bhatia, 2010. Kelaher et al. SS&M, 2014).

identifying and addressing inequities in health risk behaviours

evidence of inequalities	potential causes?	what actions can the health system take?
differences in important modifiable medical and behavioural risk factors	people have limited knowledge, skills, and confidence in taking action to promote or maintain good health	provide credible, intelligible, relevant **health information** to all social groups; increase **diversity of workforce** (language, culture, gender, age);
	people's living and working conditions influence their behavioural choices	use **Equity Focused Health Impact Assessment** to review programs and policies – their inclusion of excluded social groups in design and delivery, their reach, likely impact, and options for improvement work with systems to reach and have greatest impact on conditions for most marginalised **(Healthy Together Victoria – food system)**

identifying and responding to inequities in access to social determinants of health and their impact

evidence of inequities	potential causes?	what actions can the health system take?
differences in material living conditions	limited recognition of living conditions (e.g. child blind housing) limited research on differences in material living conditions of different social groups (e.g. socioeconomic groups; some immigrant groups; Aboriginal peoples & Torres Strait Islanders) employees' training, cultures, experiences do not 'match' those of the communities in which we work	**identify the conditions** and explore how they affect health and health behavioural choices **refer/connect people** with appropriate assistance in the short term and contribute to **long-term policy options** appoint a **workforce** that 'matches' the population

the health system also contributes to equity by

- working in partnerships across sectors – *expanding ideas;*
- creating spaces in which to include the formal representation of marginalised groups in decision-making – *increasing presence*;
- advocating through professional organisations – *expanding ideas*;
- conducting and disseminating results of surveillance and research – *creating evidence*;
- contributing to public and health policy formulation, implementation, and evaluation – *expanding ideas*;
- reflecting on, and revising public health practice – *increasing the recognition of our contributions to inequity.*

the health system is also a powerful source of evidence to inform, advocate for, and facilitate social change

evidence of inequalities	potential causes?	what actions can the health system take?
differences in material living conditions shaped by public policy	public policy distributing resources unfairly & unjustly	ensure **presence** of marginalised groups in accumulating evidence (e.g. EFHIA) form **partnerships** across sectors **advocate**
differences in material living conditions shaped by economic and political structures and their justifying ideologies	the ideologies that shape the decisions of the health system (public, private) the ideologies that shape the decisions of the health system, the market, and civil society limited critical health literacy even within the health system	review & **reveal the ideologies** & their impacts on equity & health review **and reveal the ideologies** & their impacts on equity & health **facilitated dialogues**

and finally, as informed informed citizens

evidence of inequalities	potential causes?	what actions can citizens system take?
differences in the political power and influence of those who create and benefit from health inequalities	the lack of presence in decision-making spaces of the social groups that have been most affected biases in views on social justice - belief that societal obligations have been met by the provision of universal constitutional and legal rights belief in natural and behavioural causes only	• become critically health literate • create spaces to enable the presence of excluded social groups • seek political power • form social alliances • advocate • vote

in addition, health professionals are citizens who have roles as

- voters and advocates
- instigators or members of social movements (facilitators, for example, of dialogues)
- participants in civil society

- participants in deciding on the fairness and justice of the distribution of society's resources
- judges of what is unfair and unjust (or fair and just) and in influencing others

The health system is not the only avenue through which to act to increase health equity – necessary, but not sufficient

the health system is one mechanism through which human intent is applied

- as informed members of our society who can predict the inequitable impacts of public policy decisions it is our responsibility to act wherever we can to contribute to equitable health outcomes.

five conclusions

- value our health system and its contributions to reducing inequities in health;

- examine and identify ways to overcome the biases of our health system and its workforce (as the World Bank has begun to do); and of our societies' institutions
  - about causes of inequities (natural, personal choice, socially determined)
  - about preferred responses
  - about what changes are possible and desirable – which, and how large

- establish a health equity infrastructure

- take action wherever you are

add presence to the search for ideas

- the major focus of initiatives to identify 'how to reduce inequities in health' is a search for ideas about **what** to do.

- there is equal need to focus on initiatives that seek to increase the presence of social groups that have limited representation in decision-making – within the health system and across society.

- if the social groups who are most marginalised and disadvantaged are not 'in the room' and 'at the table' the ideas for progress that are generated will continue to be insufficient and inadequate.

- Only through presence will claims for freedom, equality, and democracy be able to be expressed adequately.

Hofrichter R. Tackling health inequities: a framework for public health practice. 2nd ed. Oxford: Oxford University Press, 2010.
Young I. Structural injustice and the politics of difference. 2008.