Section 8

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Introduction

The early sections in the atlas provide information to assist the health sector in addressing social exclusion through an understanding of the relationships between health and wellbeing, poverty and social exclusion, across the life course. In addition, the particular population groups who are significantly disadvantaged and at risk of social exclusion, are reflected in the indicators described in the later sections.

Discussion

The extent of variation across Australia in health and wellbeing is shown in the maps in Section 4; and the graphs in Section 5 highlight both the variation across the population, from the least disadvantaged (through the intermediate groups) to the most disadvantaged, as well as the size of the gap between these two groups. The consistent pattern painted by the maps and graphs indicates the extent to which the populations in many areas face multiple disadvantages.

For example,

- the percentage of children in jobless families increases consistently with increasing socioeconomic disadvantage in both the major urban centres and rest of state areas, with almost five times as many children in this group in the most disadvantaged areas in the major urban centres, and three times as many in the rest of state areas;
- the results of the AEDI show that around 30% of new primary school students are assessed as being developmentally vulnerable on one or more domains in the most disadvantaged areas, regarded as important for their readiness to learn, health and development;
- those who are unemployed long-term, and children in families where the mother has low educational attainment, are similarly distributed, indicating that these are not short-term occurrences;
- premature death rates (deaths before 75 years of age) in the major urban centres are 55% higher for people from the most disadvantaged areas, and 38% higher in the rest of state areas; and
- the median age at death for Aboriginal people and Torres Strait Islanders varies from 18 years lower than for other Australians in the most advantaged areas, to 24 years lower in the most disadvantaged areas, providing just one example of the much poorer health outcomes of this population group.

Some of the indicators show the impact of disadvantage over time. For example, although the proportion of the population under 16 years of age living in low income, welfare-dependent families declined from 2002 to 2011, this group has been increasingly marginalised, to the extent that they now comprise four times the proportion in the most disadvantaged areas, within the major urban centres, when compared with the least disadvantaged areas. This compares with a differential just under three times (2.89) in 2002. The comparable figures for the non-metropolitan areas are 61% in 2002 and over twice the level in 2011.

In addition, although premature mortality has fallen by 40% over the period 1987 to 2007, the impact on the socioeconomic inequality between groups has been minimal. In the major urban centres, the gap in death rates between those from the most disadvantaged and the least disadvantaged areas in the major urban centres has increased, from 47% at the beginning of this period to 55% in the most recent years. In the non-metropolitan areas, the gap has narrowed, down from 56% to 38%, but still represents a major difference in the population's life expectancy.

The results of the cluster analysis in Section 6 and the correlation analysis in Section 7 support these findings.

Conclusion

There is substantial evidence that supportive social, biological and ecological environments provide a foundation for the development of competence and skills that underpin the population's wellbeing, health, learning, and behaviour throughout life. Conversely, a lack of enabling social conditions can result in poorer life outcomes for people, and may adversely influence subsequent generations.

The findings in this atlas highlight areas where further action is needed, and there is much that can be done. There is a growing body of knowledge that provides direction for developing policies to reduce inequalities across the population. The atlas can be used to support a social inclusion policy approach and provide information to assist in monitoring its success. It can help to build our capacity to reduce inequalities, by providing planners, community

advocates and service providers with information on which to base their decisions and proposals.

Addressing the determinants of health and social inclusion requires action from a wide variety of government and non-government organisations, and communities themselves, and the socioeconomic environment is a powerful and potentially modifiable factor. Public policy is a key instrument to improve this environment, particularly in areas such as housing, taxation and social security, work environments, urban design, pollution control, educational attainment, and early childhood development; and the publishing of this atlas supports those committed to creating a fairer and more socially inclusive community.[121]