

Section 2

Health, inequality and social exclusion

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A focus on health inequality and social exclusion

Overall, the level of wellbeing in Australia is high when compared to many other countries, as evidenced by life expectancy and infant mortality rates for the population as a whole.

However, there are substantial differences in the wellbeing of specific groups within the population. For example, compared with other Australians, Aboriginal and Torres Strait Islander peoples are disadvantaged across a broad range of social and economic factors, including education, health, employment, income and housing.^{1,3,118} This is the result of many underlying causes, including the intergenerational effects of forced separations from family, community, land and culture, and the lasting impacts of colonisation, racism and discrimination.^{1,2} This has placed them at greater risk of poorer life outcomes; and there has been substantial evidence for decades, that, for example, the health of Aboriginal and Torres Strait Islander peoples is significantly worse than that of the non-Indigenous population.¹⁻³

These and other differences in health are known as 'health inequalities'. Inequality simply means 'being unequal', not the same. Many inequalities exist across the population and they tend to divide the community into different groupings, depending on the measure used.^{4,5}

Inequalities may result from differences in age, sex, ethnicity, social and economic position, gender, ability, geographical area, remoteness, and so on. Some dimensions of inequality are unavoidable and not amenable to change, such as age. Other inequalities occur as a result of differences in access to effective services, educational opportunities, material resources, safe and satisfying work, nurturing experiences and living conditions in childhood, and so on.⁶

Many of these inequalities are potentially avoidable, and the fact that they exist implies a degree of unfairness, or 'inequity'. Inequities occur as a consequence of unjustifiable differences in opportunity, which result in poorer access to effective services, nutritious food, adequate housing, safe transport and so on, with consequences for population wellbeing.⁶ Such inequities can also lead to limited opportunities for full participation as citizens in society, and thereby, to social exclusion.² A lack of opportunity can also alter people's expectations of what life offers in the future.

Social exclusion may occur as a result of a lack of the capabilities needed to participate in the

experiences that lead to social inclusion: "(social) inclusion is characterised by a society's widely shared social experience and active participation, by a broad equality of opportunities and life chances for individuals and by the attainment of a basic level of wellbeing for all citizens".⁷ Thus, for many Australians, exclusion from the opportunities, capabilities and resources to choose a fulfilling life is reflected in their poorer health, and in potentially avoidable inequalities in wellbeing. Notions of exclusion also infer that the cumulative impact of individuals' lack of resources and capabilities can act as a critical barrier to social integration, often leading to a transfer of disadvantage and inequalities in wellbeing from one generation, to the next.⁸

The impact of the various domains of social exclusion also differs for individuals or subgroups of the population at certain points in the life course, and these interact with each other. For example, a certain level of income may deliver social inclusion for a young healthy person but not for an older, unwell person who has higher needs for additional resources and support.⁹

Thus, a social inclusion approach involves 'the building of personal capacities and material resources, in order to fulfil one's potential for economic and social participation, and thereby, a life of common dignity'.⁹

Tackling social exclusion, therefore, suggests a broader way of both defining and measuring poverty and disadvantage, and of describing a social policy approach that focuses on investing in people's capacity to negotiate the various challenges of life.¹¹ It also means highlighting the localised nature of inequality and disadvantage, the multiple disadvantages faced by those who are socially excluded and the process that has led to social exclusion, to facilitate the development and implementation of localised and tailored approaches to remedy the situation for affected peoples and communities.¹⁰

The impact of social and economic inequalities

Economic inequality is evident in the uneven distribution of wealth in society. It implies an unequal distribution of the ability to purchase 'goods' such as housing, education, recreation, health care and other opportunities, and the choice to do so.¹²

Social inequality is the expression of the lack of access to these opportunities and represents a

degree of exclusion of people from full and equal participation in what we believe is worthwhile, valued and socially desirable.¹²

Thus, economic and social inequalities are inextricably linked, and their combined impact results in limited opportunities and life chances for many who are affected by them.¹³ Such inequalities tend to stratify the community into hierarchies, with those who have the most resources, opportunities and power to choose, at the top; and those with increasingly less, in layers below them. The effect of these hierarchies is to entrench differences in wellbeing across the population, and to limit capacity to have a fulfilling life.¹³ Those who sit at the bottom of the hierarchy are the most likely to experience social exclusion, and the poorest health and wellbeing.¹⁰⁵

Socioeconomic disadvantage takes many forms. For some, it is the inability to obtain the essentials of life such as shelter and adequate food; for others, it is a matter of low income; for others, a problem of discrimination and exclusion from opportunities in society.¹³ Defining disadvantage only in terms of poverty or low income minimises the importance of access to appropriate services, safe environments, and the quality of housing or level of education that is available.¹³ A complete definition needs to extend beyond a lack of economic resources to encompass many of the serious structural, social and environmental issues faced by individuals, their families and their communities.^{14,15,118} Examples of these include under- and unemployment, homelessness or insecure housing, discrimination and racism, unsupported sole parenthood, disability, educational under-attainment, violence and abuse, and behavioural and mental health problems.

Extending the definition of socioeconomic disadvantage beyond a lack of money to include restriction of access to opportunities, and limitations in the capabilities required to capitalise on these, reflects the wider dimensions of social exclusion.¹⁶ For many disadvantaged groups within the population, the impact of inequality and social exclusion limits their ability to influence change, and makes them more vulnerable to poorer health and wellbeing. Some of these groups include Aboriginal and Torres Strait Islander peoples, people living with disability and their carers; young offenders; children living in jobless households; homeless families; people with mental health problems; and refugees from a range of cultures and ethnic backgrounds.¹⁶

Increasing inequality and social exclusion are matters for significant community concern, because they tend to unravel the fabric of society, through adverse effects on individuals' life chances and their ability to participate as active citizens in all areas of community life. These effects may be handed on from generation to generation, thus creating a cycle of disadvantage and social exclusion.¹⁷ The 'hidden damage' from social and economic inequalities can affect every aspect of life: from the ability of an individual to learn and the foundations of health laid down in early childhood, the strengths of neighbourhoods and the productivity of businesses, to Australia's collective identity as an inclusive community.

Families and communities are the building blocks of society and national life.¹¹⁵ The quality and strength of people's relationships with others - their families, friends, neighbourhoods and the wider community - are important ingredients of a cohesive and inclusive society.¹¹⁵ An equal society protects and promotes equal freedom and substantive opportunity to live in the ways people value and would choose, so that everyone can flourish.¹¹ An equal society recognises people's different needs, situations and goals and removes the barriers that limit what people can do and be.¹¹ In a socially inclusive community, the focus is on citizens' rights not on charity, on the society as a whole, not on 'an underclass', and assumes positive government intervention in order to tackle structural inequalities.¹⁸

Social exclusion, poverty and health

The concepts of social inclusion and social exclusion have been the subject of much discussion and review internationally and in Australia, especially with regard to how each is defined, measured and understood within the community.^{67-70,118}

For the purposes of the atlas, social inclusion is considered a positive concept: "people having the necessary opportunities, capabilities and resources to enable them both to contribute to and share in the benefits of society".⁷¹ Social inclusion is recognised as important for health and wellbeing, with good health laying the foundation for, and resulting from social inclusion.^{72,73} It also is an acknowledgement of the broader social and economic structures that lie beyond the control of the individual or their local community in determining wellbeing.^{72,73}

The idea of social exclusion is generally used to facilitate a broader understanding of the multiple dimensions of poverty and their impacts on wellbeing.⁷⁴ While poverty and social exclusion are closely related, social exclusion has been

described as ‘the existence of barriers which make it difficult or impossible for people to participate fully in society or obtain a decent standard of living’.⁷⁵ While income poverty is the most commonly cited cause of social exclusion, other examples of barriers include disability, lack of educational opportunity, inadequate or insecure housing, ethnic minority status, unemployment, age, gender or sexuality, and lack of transport.⁷⁴

Four aspects of social exclusion are described:

- impoverishment or exclusion from adequate income or resources;
- labour market exclusion;
- service exclusion (lack of basic services within the home and outside of it); and
- exclusion from social relationships, which can be illustrated by non-participation in social activities with family and friends, isolation and lack of support, civic disengagement and confinement.⁷⁶

However, the distinctions between causes or drivers and outcomes of social exclusion are often unclear.⁷⁶ The rationale for using a social inclusion approach is that the way of ‘including’ people with these disadvantages is not only, or even necessarily, to give them more money but also to attend to their specific sources of exclusion.⁷⁴

Therefore, remedies need to deal with the “circumstances where people are prevented from participating fully in economic, social and civil life” that is, to strengthen the social connections, economic processes and political and cultural networks that bind individuals together as a

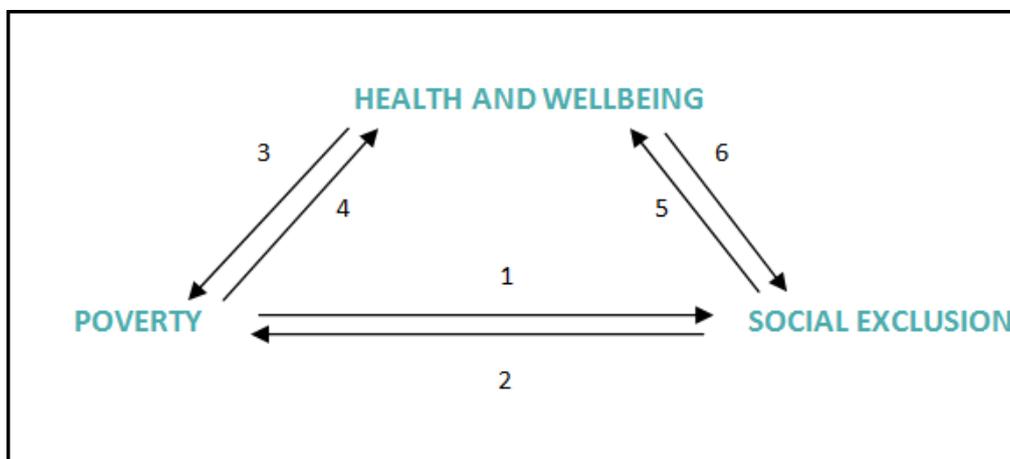
community.^{77,78} For many Australians, exclusion from the opportunities, capabilities and resources to choose a fulfilling life is reflected in their poorer health, and in avoidable, unjustified inequalities in wellbeing.⁷³ Exclusion also suggests that the cumulative impact of individuals’ lack of resources and capabilities can lead to intergenerational inequalities in health and wellbeing.⁷⁵

Exploring how the health sector can address social exclusion requires an understanding of the relationships between health and wellbeing, poverty and social exclusion.⁷⁹ Poverty, social exclusion, and health and wellbeing are closely inter-related. Each can be a cause or a consequence of the others and the relationships between them may be cyclical (Figure 1).⁷⁹ For example, many of the mechanisms leading to and perpetuating poor health across generations are related to poverty and social exclusion early in life.⁸⁰

The specific population groups, who have been identified by research as more likely to face social exclusion in Australia, include people living with disability or mental illness, refugees, Aboriginal and Torres Strait Islander peoples and immigrant ethnic groups who experience racism and other forms of discrimination, unsupported sole parents, people with caring responsibilities, and children growing up in jobless households.^{34,80} The experiences of these groups also illustrate the ways in which chronic poverty can lead to social exclusion, and how the experience of being excluded can lead to, or compound, poor health.^{33,79}

Figure 1: Relationships between health and wellbeing, poverty and social exclusion

(Adapted from Stegeman & Costongs 2003)



Poverty and social exclusion

Poverty can be a cause of social exclusion when those who are poor become increasingly marginalised due to their lack of resources and, as a result, have fewer opportunities to participate in society (Figure 1, link 1). People living in low-income households are more frequently disadvantaged in non-monetary terms than the rest of the population.⁷⁷

However, poverty is not the only indicator of social exclusion. There are some people who receive income support or who own assets that place them above the relative poverty line, who may also be socially excluded. Factors such as disability, insecure employment, caring for frail aged or disabled members of their families, and so forth may lead to them not being able to participate in the community and to being socially excluded.⁷⁷

Social exclusion can, in turn, lead to poverty (Figure 1, link 2). People who are discriminated against on the basis of disability, mental illness, race, gender, sexual identity or age may be unable or may not have the opportunity to engage in economic activity and thereby, be income poor.⁸¹

Although poverty and social exclusion are closely related, one does not necessarily result in the other. While poverty can lead to and may be paired with social exclusion, there are people who may be income poor, but who participate actively in their communities, and are not socially excluded.⁷⁹

Poverty and health

As discussed, health and wellbeing are important in the pathways that run from poverty to social exclusion and from social exclusion to poverty. A strong association between poverty and health is evident from the large body of research which indicates the marked correlation between socioeconomic position and health at an individual and a population level.⁸²⁻⁸⁴ The association is a graded one: socioeconomic position is important to health across all levels of society. The conditions of poverty result in poor health and premature death ('health causation'), although unpicking the mechanisms of causation is a difficult task.⁷⁹ There are clearly effects at the level of an individual; and, although it is true that people who are chronically unwell may become poor, it is much more evident that poor people tend to become unwell. Socioeconomic factors have a direct bearing on how long a person lives, their wellbeing and quality of life and on the burden of disease to which they will be

exposed.⁸³ Those who occupy the lowest socioeconomic position fare the worst (Figure 1, link 4).

An individual or family's socioeconomic status reflects their relative position in society. This relative position is operationally defined by indicators such as educational attainment, occupation, income and house or car ownership. These variables are therefore considered to provide a good indication of the likelihood that individuals will be exposed to health damaging factors or possess particular health enhancing resources.⁸⁵ Furthermore, evidence from health research shows that social and structural conditions can be as influential on the health of a population as are the behaviours and characteristics of the individuals of which the population is comprised.⁸⁵

For some people, chronic and severe health problems may preclude their employment and economic participation, and lead to downward social mobility and poverty ('health selection') (Figure 1, link 3). Reduced earnings due to an inability to work, caring responsibilities, or a change in life expectancy can play a role in pathways that run from ill health to poverty.⁸⁸ However, health selection usually plays a relatively minor role in contributing to the socioeconomic gradient: the effect of health selection on the gradient is variable across gender and life stage, of modest size and cannot be regarded as a major explanation for inequalities in health.^{89,90}

Health and social exclusion

The mechanisms described above which lead to the association between poverty and ill health are, in many cases, similar to those that link social exclusion to poor health and wellbeing.⁷⁹ Central to these relationships are the key determinants that influence health status and wellbeing.⁷⁹ For example, psychosocial factors may be significant in understanding the mechanisms that move from social exclusion to poor health, while the socioeconomic environment plays an important role in patterning health-related behaviour.⁷⁹ However, the underlying mechanisms behind socioeconomic differences in health and wellbeing are not yet fully understood.⁹¹

As discussed earlier, social exclusion is socially defined, and is often a characteristic of vulnerable groups within the population – the frail aged, those living with disabilities, those who are socially or geographically isolated, and those from certain minority ethnic backgrounds.⁷⁹ These groups are also likely to experience poorer health and wellbeing (Figure 1, link 5).

Social exclusion can also occur as a direct result of health problems, disability or physical limitations (Figure 1, link 6). Societies that enable all citizens to play a full and useful role in the social, economic and cultural life of their society will have healthier populations than those where people face exclusion and deprivation.^{21,78}

Determining health and wellbeing

Health is a complex phenomenon and the result of many different factors, which have collectively been called 'the determinants of health'.¹⁰⁶ They can be illustrated as 'layers of influence', starting with individual factors, and extending to aspects of families, neighbourhoods and the wider community (Figure 2).¹⁹ This model links influences from various domains – including society-wide factors (e.g., socioeconomic, cultural, environmental), middle-level factors (e.g., health care) and individual factors (e.g., tobacco use, genes, age), to explain the origins of a whole population's health and wellbeing.¹⁹

While health care services make a direct contribution to the health and wellbeing of a community, the model shows that many other determinants are found in sectors such as education, housing, employment, and the physical environment.

The health effects of social conditions have been described as the 'social determinants of health'.¹⁰⁶ Many social determinants can potentially be modified to improve personal and population health outcomes.

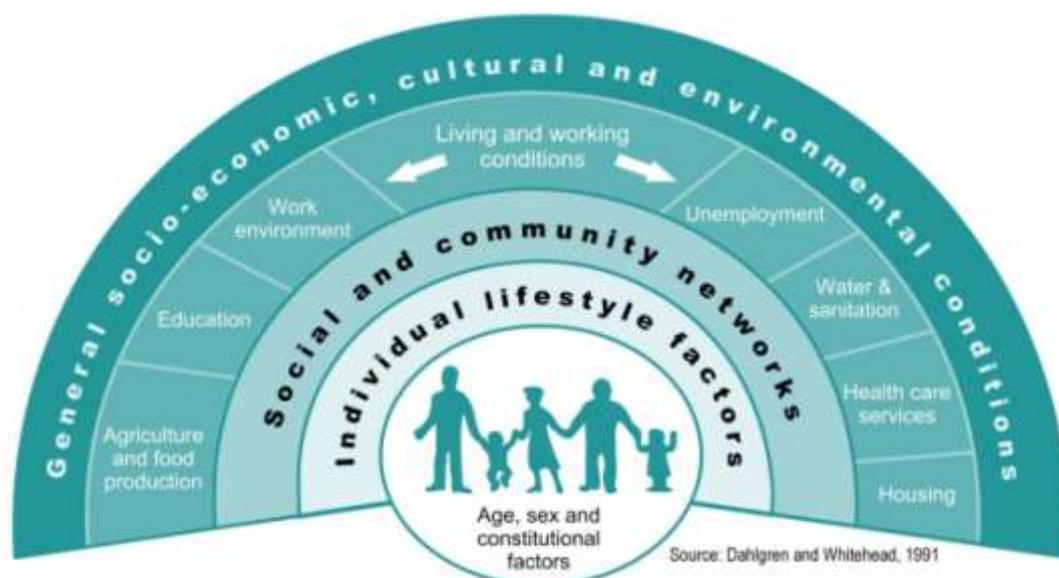
The World Health Organization (WHO) has identified the following areas as ones where

action ought to be taken to reduce inequalities in health by modifying the social determinants: stress; early life; social exclusion; the social gradient; work; unemployment; social support; addiction; food; and transport.²¹

As shown in Figure 2, health and wellbeing are the result of multiple determinants that operate together, within genetic, biological, behavioural, social, cultural, environmental and economic contexts, which have differing influences at various points in our lives. For example, the family context has a greater effect on the wellbeing of infants and young children early in life, while neighbourhood and peer group factors and individual behaviours become more important as older children move into adolescence and adulthood.²² The life pathways that result are the product of cumulative risk and protective factors and other influences. A single risk factor (being obese or having experienced child abuse) may contribute to a wide range of problems, just as one protective factor (good nutrition or having a supportive family) may help to defend against other difficulties.²³ Risks and protective factors can occur independently, or may cluster together in socially patterned ways.²²

Taking a life course approach to health and wellbeing means examining the long-term effects of physical, emotional and social exposures to risk and protective factors during gestation, infancy, childhood, adolescence, young adulthood and later adult life.²⁴

Figure 2: The Key Determinants of Health and Wellbeing²⁸



The path that leads to any particular outcome may be very different for different individuals

and populations. The timing and sequence of biological, cognitive, psychological, emotional,

cultural and historical events and experiences will all influence the development of health and wellbeing in both individuals and across populations.²⁶

Key determinants of health and wellbeing

The key determinants of health are described in more detail below and reflect many of the indicators which are included in Section 4 of the atlas. Numerous determinants overlap, and more remains to be learned about the specific ways in which determinants influence health and wellbeing.

1. Wealth and socioeconomic position

These are among the most important individual-level determinants, and one's overall wellbeing tends to improve at each step up the economic and social hierarchy. Thus, people with greater wealth generally enjoy better health and longer lives than people with less.^{4,5} The rich are healthier than those with mid-level income, who are in turn healthier than those who are poor. This is known as 'the social gradient'.

In Australia, many health outcomes vary by socioeconomic position - for example, risk behaviours (such as smoking, obesity); a range of chronic diseases (such as type 2 diabetes, cardiovascular disease, some cancers); Health-Adjusted Life Expectancy (HALE); and mortality.²⁷ Furthermore, a gradient exists for other outcomes - from coping behaviours, to literacy and mathematical attainment.²⁸ The gradient is evident whether one looks at differences in current socioeconomic status or in that of family of origin. These effects seem to persist throughout the life course, from birth, through adulthood and into old age, and for some outcomes, to the next generation.^{25,29}

For most people in Australia, this variation in health and wellbeing is not due primarily to the lack of money for food, clothing or shelter. Thus, the important factors in explaining differences appear to be not only material conditions, but also the social advantages and power attached to those conditions, such as social inclusion. In mature economies such as Australia, these are major influences on health and wellbeing.

2. Culture and kinship

The concept of culture reflects a shared identity based on factors such as common language, related values and attitudes, and similarities in beliefs, lived histories, and experiences. For many people, the expression of these aspects of their culture is an enabling and protective factor

for their wellbeing.³⁰ Culture, spirituality and kinship have overarching influences on beliefs and practices related to health and healing, including concepts of wellbeing and knowledge of the causes of health and illness and their remedy.

However, minority groups can face serious risks to their wellbeing because of dominant cultural values that contribute to their discrimination, loss or devaluation of language and culture, marginalisation, poor access to culturally responsive care and services, and lack of recognition of skills and training.³¹ This results in avoidable and unfair inequalities in power, resources or opportunities across groups in society.

Racism, discrimination and social exclusion may be expressed through beliefs, prejudices, behaviours and practices; and can be based on race, ethnicity, gender, sexuality, disability, culture or religion.³² Such phenomena have direct impacts on health and wellbeing, and indirect effects are mediated through various forms of social and economic inequality.^{31,33} These concepts are clearly applicable to Australian society, and include the effects of racism and discrimination on Aboriginal and Torres Strait Islander peoples, people living with disability or mental health problems, refugees and recently arrived migrants, and others.^{32,34}

3. Education and training

Education increases opportunities for choice of occupation and for income and job security, and also helps to equip people with the skills and ability to control many aspects of their lives - key factors that influence wellbeing throughout the life course. Participation in schooling and training is also a major protective factor across a range of risk factors, including substance use and homelessness for young people.

In Australia, evidence shows that health also improves with increasing levels of educational attainment.^{25,35} Educational attainment and participation are steeply graded according to socioeconomic position.^{25,35} The pervasive socioeconomic inequalities in adult learning outcomes (and many other markers of wellbeing) have many of their roots in socioeconomic inequalities in early child development. That is, during the earliest years of life, differences in the extent of benefit provided by children's social and living conditions lead to differences in early developmental outcomes; and the effects of early inequalities can translate into inequalities in learning, development and wellbeing in later childhood, adolescence, and adulthood.^{25,35}

4. Employment and working conditions

For employed people, those who have more control over their work and fewer stress-related demands in their jobs are likely to be healthier.^{36,37} Workplace hazards and injuries are significant causes of disability and related health problems.³⁶ Furthermore, those who do not have access to secure and satisfying work are less likely to have an adequate income; and unemployment and under-employment are generally associated with reduced life opportunities, greater likelihood of social exclusion and poorer health and wellbeing.³⁷⁻³⁹

While many of the most disadvantaged households are in Australia's remote Aboriginal communities, there are also concentrations of highly disadvantaged households within certain neighbourhoods in urban and regional communities.^{117,118} These concentrations of disadvantage are often reinforced by the uneven distribution of access to employment and other opportunities.^{117,118} Access to employment is critical to levels of labour force participation and to the flow-on effects for household income and wealth, and community wellbeing.

5. The physical environment

Another significant health determinant is the safety, quality and sustainability of the physical environment (the natural and built environments), which provides the basic necessities for life, such as clean air, water and food; and raw materials for clothing, shelter and industry. Features of the natural and built environments also offer different opportunities for social interaction, safe recreation and play, transportation, work and housing. For example, a lack of access to transport or adequate housing is a risk factor for poorer wellbeing and social exclusion of people and their communities, as is pollution of the air, water or soil.⁴⁰ The effects of changes in climatic conditions, altered cycles of flooding and drought, and the disruption of ecosystems on communities pose further challenges for health and wellbeing, and are likely to affect populations unequally.⁴¹⁻⁴³

Physical environments that jeopardise safety, undermine the creation of social ties, and foster abuse or violence are also likely to be unhealthy and socially excluding. A healthy environment, in contrast, provides safety, opportunities for social integration, and the ability to predict and control aspects of that setting.⁴³

6. Social support networks

Better health and wellbeing are associated with access to support from families, friends and

communities. Aspects of these shape people's daily experiences, and include individual and neighbourhood socioeconomic characteristics, a sense of connectedness, community norms, and spiritual and cultural beliefs and practices. Such sources of support help people to deal with crises and difficulties as they arise, to maintain a sense of control over their lives, enhance their resilience to life challenges, and to feel able to contribute as members of a community.^{44,45}

Researchers also describe the quality of the social context of everyday life ('social quality') as having four conditional factors: socioeconomic security, social cohesion, social inclusion and social empowerment.¹⁰⁸ These factors are underpinned by the rule of law, human rights and social justice, social recognition/respect, social responsiveness and the individual's capacity to participate as a citizen.¹⁰⁸

7. Early life factors

Early life is a time when people are particularly vulnerable to risk and protective influences.²⁵ Experiences at the beginning of life are reflected in health and wellbeing outcomes during the middle and end of life. There is strong evidence of the effects of supportive, early experiences on cognitive function, growth, the ability to learn, physical and mental health, and resilience in later life.²⁵ Exposure to neglect, trauma, violence and abuse in childhood and beyond, carries a risk of poorer physical and mental health throughout life, with adverse consequences for later learning, development, relationships and wellbeing.⁴⁶

A life course view highlights the sequencing of events across an entire lifetime. There is also evidence for intergenerational effects: for example, the socioeconomic status of a child's grandfather may predict the child's cognitive and emotional development at 14 years of age.⁴⁷

8. Individual behaviours and practices

Personal behaviours, practices, and coping mechanisms can promote or compromise health and wellbeing. Factors such as physical inactivity, tobacco smoking, use of drugs and excessive alcohol, food habits, exposure to violence and trauma, and gambling have obvious impacts. However, many of these health behaviours reflect decisions that are patterned by an individual's and community's economic and social circumstances.⁴⁸ Policy in this area therefore also needs to focus on these wider contexts, if individuals are to be truly able to be responsible for their own health.⁴⁹

People with low incomes have access to fewer alternatives to help reduce stress and cope with

life's challenges. As a result, they may be more likely to take up readily available and more economically accessible options, such as tobacco smoking.⁵⁰ Not surprisingly therefore, smoking behaviour is steeply graded according to socioeconomic status, resulting in those who are the most disadvantaged having the poorest smoking-related health outcomes.^{51,52} Not only does prevalence of smoking increase with socioeconomic disadvantage, but the average number of cigarettes smoked per week also increases with growing disadvantage.⁵³

Personal attributes and risk conditions interactively shape wellbeing and health. However, people who suffer from adverse social and material living conditions can also experience high levels of physiological and psychological stress.⁵⁴ Stressful experiences arise from coping with conditions of low income, homelessness or poor quality housing, food insecurity, unsafe communities, inadequate working conditions, unemployment or under-employment, and various forms of discrimination based on Aboriginal and Torres Strait Islander status, mental illness, disability, religion, gender, sexuality or race.^{54,55} A lack of supportive relationships, social isolation, and a mistrust of others further increases stress and reduces wellbeing.^{54,55}

9. Access to effective and timely services

The use of effective services is a determinant of health and wellbeing, especially the accessibility of preventive and primary health care services that are universally available, high quality, safe, and culturally responsive. For certain populations who are socially marginalised or geographically remote, lack of access to and availability of appropriate services continue to be important influences on their health.⁶⁶ For example, in Australia, people living in isolated rural and remote areas may have lower incomes; less education and employment; poorer life expectancies (particularly in remote Aboriginal and Torres Strait Islander communities); higher rates of risk-taking behaviour, such as smoking and excessive alcohol consumption; greater risks of workplace and road-related injury and death; increasing physical and social isolation; as well as limited access to health and other services.¹⁰³ This requires the targeting of resources and services specifically to address their greater need.⁵⁶

10. Gender and sexual identity

A gendered approach, while not excluding biological differences, considers the critical roles that social and cultural factors, and power

relations between men and women play in promoting and protecting or impeding health and wellbeing.⁵⁷ Understanding gender in this way involves addressing and analysing the social distribution and exercise of power and its consequences. This includes not only the distribution of socially valued resources, but also the social inclusiveness of the processes that determine what are considered socially valued resources.⁵⁸ The aim is to contribute to the attainment of equitable resource distribution, population wellbeing, social inclusion and participation.

Gender- and sexuality-specific health needs include the adequacy and appropriateness of health care and other service provision; and the wellbeing of both males and females is shaped by the distribution of available social and economic resources. For some people within the population, such as many gay, lesbian, bisexual, transgendered and intersex Australians, inequalities in health and wellbeing also arise as a result of the considerable stress of experiencing stigma, discrimination, trauma and social exclusion from the wider community.^{59,60}

11. Disability

Understanding the distinction between individual and social models of disability is critical to recognising disability as a key determinant of wellbeing.⁶¹ When disability is thought of only as a personal tragedy or a form of biological deficit, action tends to focus on medical responses of care, cure or prevention. By contrast, social model approaches focus not on presumed deficiencies within an individual, but on the social processes that cause people with perceived impairments to experience inequalities and social exclusion as a minority group in society.⁶² A social model of disability acknowledges that the causes of social inequalities operate beyond the level of the individual, and both structural and cultural forces play a part in the collective experience of inequality and the social exclusion of those living with disability.⁶² When the experience of disability is identified as discrimination, exclusion or injustice, policy responses are more likely to focus on human rights and the removal of barriers to inclusion.

People with disabilities experience significantly poorer health outcomes than their non-disabled peers; and these negative health outcomes extend to aspects of health unrelated to the specific health conditions associated with their disability.¹⁰¹ Poorer health outcomes are also experienced by family members who care for

disabled children and adults, and they are also at risk of social exclusion.¹⁰²

People with certain impairments may be more likely to die at a younger age than the average for the population as a result of the biological impact of the impairment on the body's capacity for survival. However, inequalities in access to health care, fulfilling employment, safe and supportive environments, and welfare resources can also affect survival chances adversely.^{62,101} These broader inequalities, including those linked to socioeconomic background, underlie the social patterning of the health and life experiences of people who live with disability and their families.¹⁰¹

12. Biologic factors and genetic inheritance

Genetic inheritance, the functioning of individual body systems, gender, and the processes of growth and ageing are powerful determinants of health and wellbeing. A person's genetic endowment was once thought to be pre-determined and not amenable to change. However, recent evidence indicates that the ways that genes are expressed are shaped by a person's particular physical, psychological and social environment; and social relationships and environments may influence the expression of DNA throughout life.⁶⁵

A growing body of research is revealing that external factors affect wellbeing and development not only via psychosocial mechanisms, but through epigenetics as well. Epigenetics refer to the mechanisms that can change a gene's function, without changing its sequence.⁶³ New research has shown that early life experience can produce changes in the genes that affect brain development; and these changes may help explain, for example, why abuse and neglect early in life result in a high risk for suicidal behaviour many years later.^{64,116}

To summarise, these factors play important roles in the health and wellbeing of populations. For example, it has been estimated that the determinants broadly contribute to premature deaths at a population level in the following proportions: genetic predisposition, about 30 per cent; socioeconomic circumstance, 15 per cent; environmental exposures, 5 per cent; behavioural patterns, 40 per cent; and shortfalls in medical care, 10 per cent.¹¹⁰ However, the health of each individual is determined by the influence of factors acting where determinants interconnect. Whether a gene is expressed can be determined by environmental exposures and also by behavioural patterns. The nature and

consequences of behavioural choices are affected by socioeconomic and cultural circumstances. Genetic predisposition and behaviour determine the health care that will be needed, and one's socioeconomic circumstances may affect the health care one receives.¹¹⁰

Understanding the mechanisms of health inequality

Evidence of effective interventions and policies is needed to address the inequalities in health which are evident across society. Tackling the social influences on health is recognised as one way to reduce health inequalities.⁹⁴ However, the social factors promoting or undermining the health of individuals and populations should not be confused with the social processes underlying their unequal distribution.⁹⁴ The distinction is important because, despite better health and improvement in health determinants, social and economic inequalities in health have persisted.⁹⁴

In considering how to remedy inequalities in health, it is necessary to distinguish between:

- the social determinants of health – which generally include the non-genetic and non-biological influences on health – meaning individual behavioural risk factors such as diet and smoking as well as wider influences such as wealth, education, housing and the environment; and
- the social determinants of health inequalities, which include inequalities in these health determinants and, particularly, inequalities in people's positions in the social hierarchy.⁹⁴

Using a single model to explain both health and health inequalities can 'blur this distinction'; and lead to the policy assumption that tackling "the layers of influence" on individual and population health will reduce health inequalities.⁹⁴ Models are needed which recognise that unequal social positions carry with them unequal probabilities of being exposed to health hazards along the social context/risk factors/illness and disease pathway.

While not all determinants are equally important in the development of inequalities in health outcomes, the most significant appear to be those that produce stratification within a society – 'structural' determinants – such as the distribution of wealth, or discrimination according to gender, sexuality, ability or ethnicity.¹⁰⁶ These determinants establish a set of socioeconomic positions within hierarchies of power, prestige and access to resources.^{94,105, 106} Mechanisms that produce and maintain this stratification include governance; education

systems; labour market structures; and the presence or absence of redistributive welfare policies.^{106, 107} These structural mechanisms, which affect the differential social positions of individuals, are the root cause of inequalities in health.

These differences shape individual health status and outcomes through their impacts on intermediary determinants such as living conditions, psychosocial circumstances, social inclusion, behavioural and/or biological factors, and the health system itself.¹⁰⁶

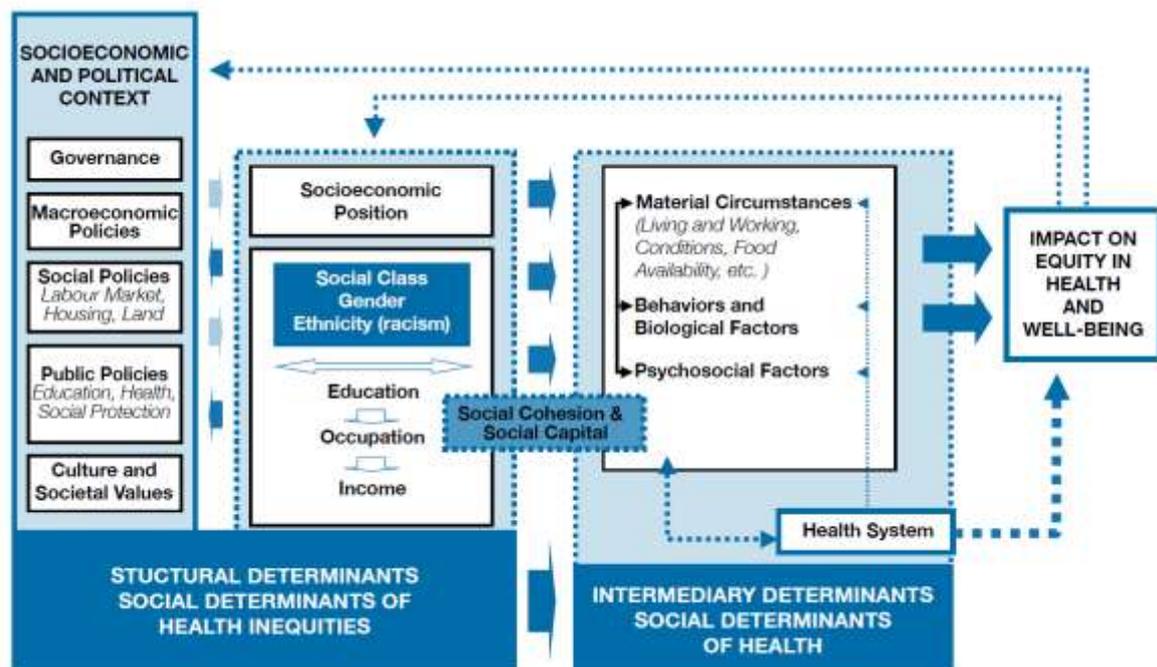
In 2005, the World Health Organization (WHO) established a Commission on the Social Determinants of Health (CSDH) to provide international advice on how to reduce avoidable differences in population health and wellbeing. The Commission's final report in 2008 contained three key recommendations for governments:

- improve daily living conditions;
- tackle the inequitable distribution of power, money, and resources; and
- measure and understand the problem, and assess the impact of action.⁹⁸

The CSDH developed a conceptual framework to bring together recent theoretical perspectives and evidence of the social production of disease (Figure 3).¹⁰⁶ The framework aims to show “how social, economic and political mechanisms give rise to a set of socioeconomic positions, whereby populations are stratified according to income, education, occupation, gender, race/ethnicity and other factors; these socioeconomic positions in turn shape specific determinants of health status (intermediary determinants) reflective of people’s place within social hierarchies; based on their respective social status, individuals experience differences in exposure and vulnerability to health-compromising conditions.”¹⁰⁶

In the framework, structural mechanisms are those ‘that generate stratification and social class divisions in society, and define socioeconomic position and are rooted in the key institutions and processes of the socioeconomic and political context’ of a community.¹⁰⁶ As such, they are the social determinants of health inequalities.

Figure 3: The WHO Commission on the Social Determinants of Health Conceptual Framework¹⁰⁶



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The underlying social determinants of health inequalities shape health outcomes via a group of intermediary determinants, which include material circumstances, psychosocial circumstances, behavioural and biological factors, and the health sector itself as a social determinant.¹⁰⁶ The role of the health sector is influential through the issues of access to effective health services, population-focused

health promotion and public health strategies, and leading intersectoral action.¹⁰⁶

The CSDH emphasises that interventions and policy approaches to reduce health inequalities need to address ‘the structural determinants by focusing on the structural mechanisms that produce an inequitable distribution of the determinants of health among population groups, and not limit their efforts to the

intermediary determinants'.¹⁰⁶ Notably, the participation of civil society groups and affected populations in the design, planning and implementation of policies to tackle the SDOH is seen as essential to success, and critical for providing an ethical and sustainable basis to underpin such efforts (refer to the WHO Discussion paper for further detail of the framework and its development).¹⁰⁶

Addressing health inequalities and social exclusion

In thinking about health inequalities and social exclusion and what each means in terms of policy design and direction, there are a number of different approaches which can be taken.^{78,92-94}

The CSDH framework asks 'at what point(s) along the chain of social production of health/illness is it desirable (and feasible) to intervene in a given context: through broad increased exposure to health threats; or by redistributive policies that aim to alter fundamental social inequalities; through less ambitious, intermediate policies that seek to shield members of socially disadvantaged groups against the worst health consequences of their providing fairer medical care at the end of the social production chain'?¹⁰⁹

There are three types of strategy that have been described to reduce health inequalities, and thereby, improve social inclusion:

- focusing solely on the most disadvantaged;
- reducing the gap between the poor and the affluent; and
- levelling the social gradient.⁹²

Such a typology can be useful in thinking about different policy approaches, and for measuring

and monitoring the absolute and relative sizes of inequalities and progress over time in addressing them.^{92,93} These approaches are described below, (and represented in summary form in Figure 4).

Focus A: The impact of social disadvantage on the health of the poorest groups in the population, such as those who are homeless, may be a priority policy goal.

Focus B: The gap between the health of those at the outer ends of the socioeconomic hierarchy (those with the poorest health and those with best health) can be a priority, with the narrowing of the gap as the goal.^{89,95}

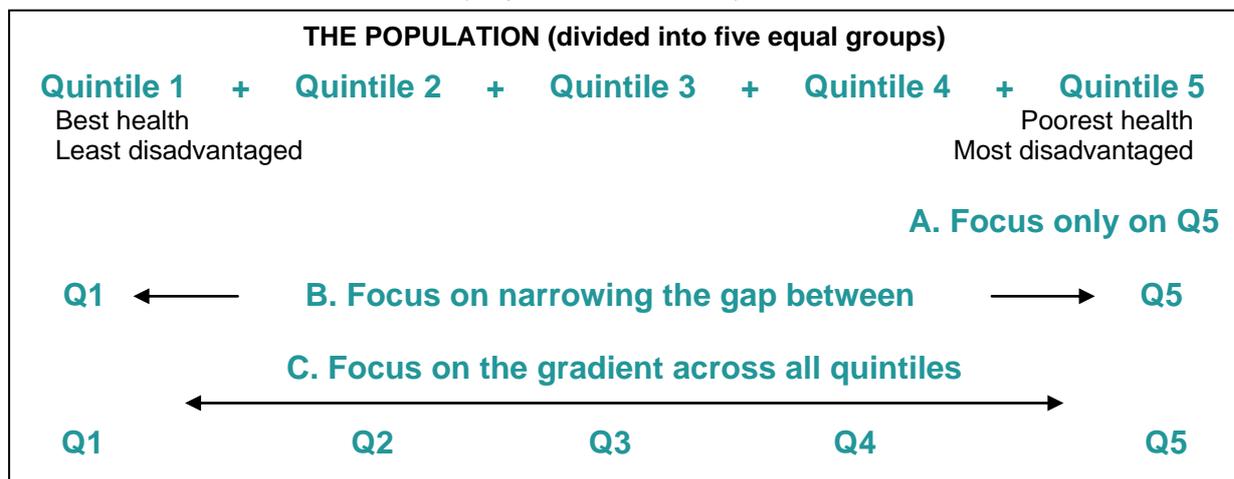
Focus C: The socioeconomic gradient in health, which runs across the whole population, can also be a focus. Australia's universal health care system which offers safe, affordable health care across the population (and which also has targeted efforts for priority groups) works towards this outcome.

Improving the health of disadvantaged groups and improving their position relative to other groups are necessary elements in a strategy to reduce the socioeconomic gradient in health and wellbeing. However, neither on its own is sufficient: to reduce the socioeconomic gradient, health of the lower socioeconomic groups also needs to improve at a faster rate than health of the highest socioeconomic group.⁹²

As an example, the last approach (Focus C) can widen the frame of health inequality policy in three ways.⁹² Firstly, it looks for the causes of health inequality in the systemic and structural differences in life chances and opportunities, living standards and behaviours that are associated with people's unequal positions across the socioeconomic hierarchy, and for the pathways through which they influence health.⁹⁶

Figure 4: Conceptualising health inequality and possible policy approaches

(Adapted from Graham 2004)



Secondly, as a result, 'addressing health inequalities' becomes a population-wide goal that includes every citizen. Thirdly, 'reducing health gradients' provides a comprehensive policy goal: one that encompasses remedying disadvantages and narrowing health gaps within the broader goal of equalising health chances across all the socioeconomic groups.^{78,92}

Therefore, a mix of different approaches, policies and programs should be mounted to address socioeconomic inequalities in health, both within the health care sector and beyond it. Approaches can include more precise targeting, but with greater attention to community-based dimensions of 'interdependence' between individual behaviours, key determinants, and community and institutional resources. Focusing solely on the most disadvantaged group is unlikely to reduce inequalities sufficiently.⁹⁷ Evidence shows that to reduce the steepness of the social gradient, actions should be universally framed, but applied with a scale and intensity that is proportional to the level of disadvantage, and culturally and locally responsive in approach.⁹⁷

In many industrially developed countries, the widening differences in socioeconomic status, which enhance inequalities in health outcomes and entrench social exclusion, are a growing concern.⁹⁸ The resultant loss of educational and economic competences in sections of the population reduces the economic and social prosperity of the nation. Tackling health inequalities and social exclusion, and implementing health equity strategies, are objectives of public policy internationally.⁹⁸

In 2010, the Strategic Review of Health Inequalities in England identified that reducing health inequality in that country required action in six policy areas:

- 'give every child the best start in life (the highest priority area);
- enable all children, young people and adults to maximise their capabilities and have control over their lives;
- create fair employment and good work for all;
- ensure healthy standards of living for all;
- create and develop healthy and sustainable places and communities; and
- strengthen the role and impact of ill health prevention'.⁹⁷

These six objectives were underpinned by two policy mechanisms: equality and health equity in all policies across government (not only the health sector); and effective interventions and

delivery systems (based on evidence that they work).⁹⁷

The report concluded that actions to reduce the steepness of the social gradient in health needed to be universal, but with a scale and intensity proportionate to the level of disadvantage. This approach was described as 'proportionate universalism'.⁹⁷ It identified that greater intensity of action was likely to be needed for those with greater social and economic disadvantage, but that a focus solely on the most disadvantaged would not reduce the health gradient sufficiently, and would only address part of the problem.⁹⁷

Strategies to remediate socioeconomic inequalities in health and social exclusion need to advance together. In Norway, the government has adopted a broad, long-term approach to reduce social inequalities in health by 'levelling up rather than down'.⁷⁸ It operates with the following four priorities:

- reduce social inequalities that contribute to inequalities in health (strategies to reduce social inequalities in income, childhood conditions and work);
- reduce social inequalities in health-related behaviour and the use of health services;
- target initiatives to promote social inclusion; and
- develop knowledge and cross-sectoral tools (use policy instruments to advance knowledge, and raise awareness about social inequalities in all social sectors by establishing a review and reporting system for monitoring progress in reducing social inequalities in health).⁷⁸

Thus, policies to remedy health disadvantages, to close health gaps and to reduce health gradients are pursued together, and not at the expense of each other.^{78,92}

In Australia, within the health sector, the extent of socioeconomic inequalities in health has been the focus of research funded by governments and non-government agencies over many years (for example, the Social Health Atlas series has documented health and social inequalities over the last two decades in its published editions and online data repository).

The delivery of universal health care via free public hospital care, subsidised medical services and medications, and preventive health and early intervention services help ensure Australians can receive the services they require and that the financial impacts of these services can be contained.¹⁰⁴ However, inequalities in health have persisted despite the benefits of universal

health care systems, although such systems are likely to have had some protective effect, when the health of populations in countries where such systems do not operate, is compared.^{112,114} Furthermore, mainstream health care services may be less effective for very disadvantaged communities who are socially excluded, have greater health risks and disease incidence, and experience barriers in accessing appropriate health care services; and further efforts are required to address their needs more specifically.^{104,111}

While reducing health inequalities are considered one of the most important public health challenges, we do not yet have sufficiently robust knowledge of which interventions are effective, in which locations and for which populations, to 'level up' the gradients in specific health inequalities. Further work is needed to monitor and evaluate alternative policies and their impacts and determine if, how and why particular populations from different socioeconomic groups respond to such policies.¹¹¹ Causes of unintended, differential impacts of current and new public policies also need to be determined.¹¹¹

However, there is a growing body of knowledge that can provide some direction for developing policies to reduce the determinants of health inequalities in modern societies.^{78,100,111} The socioeconomic environment is a powerful and potentially modifiable factor, and 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, as well as health care.²² By considering health impacts across all policy sectors such as agriculture, education, the environment, fiscal policies, housing and transport, population health can be improved and the growing economic burden of the health care system reduced.^{113,114} The health sector's role is to support other sectors to achieve their goals in a way which also improves health and wellbeing.

A focus on the social and economic contexts of life in no way implies that other factors such as genetics, behaviours or use of health services do not figure in determining health and wellbeing; rather, this highlights a greater understanding in recent years of the hidden social factors that underpin differences in the likelihood of having a healthy and fulfilling life, both for individuals and for populations. Investing in a population-focused approach to addressing socioeconomic inequalities in health and social exclusion offers a

number of benefits: increased prosperity, because a well-functioning and healthy population is a major contributor to a vibrant economy; reduced expenditures on health, education and social problems; and overall community stability and wellbeing for Australians.

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