The Royal Australasian
College *of* Physicians

Inequity and Health

A CALL TO ACTION

Addressing Health *and* Socioeconomic Inequality *in* Australia

Policy Statement

2005

HEALTH ISSUES CENTRE

ACA

Australian Consumers' Association

The Royal Australasian College *of* Physicians

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Health for All

Australians pride themselves on a 'fair go for all'. Yet at the turn of the 21st century, opportunity for a healthy life is still linked to social circumstances and childhood poverty. These inequalities mean poorer health, reduced quality of life and early death for many people. What greater inequity can there be than to die younger and to suffer more illness throughout your life as a result of where you live, what job you do or how much your parents earned?

Although this country has seen increased prosperity and reductions in mortality over the last 50 years, the gap in health outcomes between those at the top and bottom ends of the social scale remains large and, in some areas, continues to widen. Some parts of the country have the same life expectancy as the national average for the 1950s.

The reasons for these differences in health are, in many cases, avoidable and unjust – a consequence of differences in opportunity, in access to services and material resources, as well as of differences in individuals' lifestyle choices. Unfortunately, the effects can be passed on from generation to generation.

Our challenge will be to ensure that improvements in health over the next 20 years are shared by all.

What is the Issue?

On the whole, Australians enjoy good health. Australia ranks consistently in the top ten amongst OECD nations in most areas, including life-expectancy and mortality rates.

Our good health is due both to our high living standards and to the generally high standard, responsiveness and coverage of the Australian health care system.

However, Australia's overall good health is *not* shared by all Australians.

There are substantial and systematic health inequalities that cannot be explained by individual make-up or behaviour. These inequalities are most apparent amongst Indigenous Australians and amongst the socioeconomically disadvantaged.

Because such health inequalities are both *avoidable* and *systematic*, they are better described as ***health inequities.***

Compared with other developed nations, Australia has failed to reduce these inequities. In many instances, they are actually worsening.

The Royal Australasian College of Physicians has identified health inequities as one of the most pressing health problems facing Australia today.

Why Care About It?

Health inequities cost every Australian in at least two ways.

(1) Good health is a prerequisite for full participation in the economic, cultural and political life of our democratic society. To systematically restrict the participation of some individuals and groups is to diminish the character of the nation itself. It runs counter to our long-held Australian national value of a "fair go for all".

(2) Health inequities are a direct economic cost to all of us. The excess burden of diseases directly attributable to disadvantage costs taxpayers billions of dollars annually. As health inequities are growing, this places considerable financial pressure on the sustainability of the Australian health care system.

What Can Be Done About It?

The determinants of health inequities are complex. Reducing them requires strong political leadership and a comprehensive "whole of government" response.

The *Royal Australasian College of Physicians* believes that it is the responsibility of the Federal Government to provide clear and non-partisan leadership. It calls on the Federal Government to pursue a high profile national strategy to reduce inequities in health.

In addition, this statement makes 12 explicit recommendations that are supported by a growing body of world-wide evidence.

For Government:

(1) That the Federal, State and Territory Governments make immediate commitments, both strategic and financial, to improving the quantity and quality of health care services in the poorest and most disadvantaged communities.

(2) That the Department of Prime Minister and Cabinet at the Commonwealth level and the Premiers' Departments at the State level be nominated as the accountable department for 'whole of government' responses to health inequities.

(3) That the Department of Prime Minister and Cabinet and the Premiers' Departments, as part of their leadership role, commission equity-focused Health Impact Assessments for all significant developments that could affect health inequities.

(4) That the Australian, State and Territory Governments consolidate a coordinated universal approach to early childhood promotion, prevention and early intervention activities to ensure that all children get a fair start in life. The Directors-General/Secretaries of all relevant Government departments such as Health, Community Services and Education should be made accountable for the achievement of key performance indicators related to the health, development and wellbeing of all children.

(5) That the Federal, State and Territory Governments should adopt targets to close the gap in educational opportunities between different social groups. All Directors-General of Education should be made accountable for the achievement of key performance indicators.

For the Health Sector:

(6) That all health care organisations, at national, state, regional and local levels, develop an explicit plan of action to reduce health inequities for the populations they serve and in the services they deliver.

(7) That all health care organisations make such plans publicly available and report annually on progress. This will require the development of new and more appropriate information systems.

(8) That all health care service delivery and training organisations recognise the need for cultural competency in healthcare service delivery and include specific training at all levels of education and professional development.

For the Royal Australasian College of Physicians:

(9) That the RACP ensure that equity principles and an awareness of health inequities are included in basic and advanced training, and in the continuing education of all physicians and paediatricians.

(10) That the RACP encourage and enable physicians and paediatricians to review their professional practice in the light of the evidence about health inequities and the need for action.

(11) That the RACP, when assessing the suitability of health care organisations for the training of doctors, consider the adequacy of their plans to combat health inequities.

(12) That the RACP ensure that an awareness of the need for cultural competence in the delivery of healthcare is fostered in the basic and advanced training, and continuing education of all physicians and paediatricians and advocate for such principles in the teaching of medical students.

Further discussion of these can be found toward the end of the statement.

Who Are We?

Incorporated in 1938, the *Royal Australasian College of Physicians* is the professional association responsible for the training, assessment and on-going professional development of consultant physicians across 23 medical specialties.

These include Adult Medicine, Paediatrics & Child Health, Public Health Medicine, Rehabilitation Medicine, Occupational Medicine, Palliative Medicine, Addiction Medicine, Sexual Health Medicine and Intensive Care Medicine (shared with the Australian and New Zealand College of Anaesthetists).

With a Fellowship of more than 8,000 consultant physicians, committed to the provision of the highest possible quality of medical care, the RACP plays an important role in the health of the people of Australia and New Zealand.

This statement extends and continues previous policy work by the RACP in the area of equity and health, including:

> The Royal Australasian College of Physicians (1999) *For richer, for poorer, in sickness and in health: The Social Determinants of Health.* (available at www.racp.edu.au)

Please refer to Annexure for full discussion of the Royal Australasian College of Physicians and its place in the health systems of Australian and New Zealand.

The Health of Australians

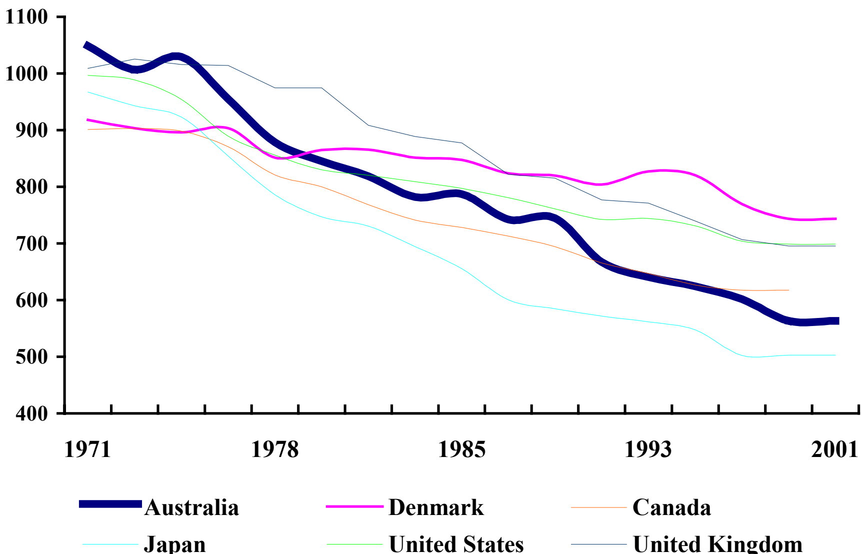
Health and health care are issues that Australians take seriously. Rarely a week goes by without political and media discussion about health and the health care system.

By international standards, Australia does very well. The *World Health Organization* ranks Australia's health as the second best in the world, when measured by both overall life expectancy and the number of years its citizens can expect to enjoy without disability.

An average Australian female born in 2000 can expect to live 82 years, 74 of them without significant disability. Likewise, an average Australian male born in 2000 can expect to live 77 years, 69 of them without significant disability. This is well ahead of women and men in the UK and the USA.

Figure 1 charts the impressive performance of Australia, relative to other OECD countries, against another common indicator of health: mortality rates over the past 30 years.

***Figure 1*: Age-Standardised All Cause Mortality Rates (per 100,000) - Some International Comparisons**



Source: OECD Health Data (2003)

This performance is testimony to higher living standards, better environments, healthier lifestyles, and improvements in health care treatments and prevention.

Medicare (including the *Medical Benefits Scheme*) and the *Pharmaceutical Benefits Scheme* deserve particular mention. These health insurance schemes are admired world-wide: both for the quality and breadth of the health-care provided, and for their effectiveness relative to total cost on the public purse.

Are All Australians Benefiting from Our Improving Health?

In short, **NO.**

These improvements in health status have not been shared equally by all Australians. There exist systematic and avoidable variations in mortality and health status that *cannot* be explained by expected differences in individual make-up or behaviour.

Inequities in the health status of Australians can be revealed in a number of ways. Most pressing, however, are the health inequities experienced by:

- Australia's indigenous populations; and
- Australians living in socioeconomically disadvantaged areas.

The Facts 1: Health of Indigenous Australians

The health of Australia's indigenous peoples remains a blot on the nation's character. No other developed country with a significant indigenous population has so wide a health gap. Canada, New Zealand and the USA are all reducing the gap in life expectancy and morbidity between their indigenous and non-indigenous populations.

The bleak facts on the health of indigenous Australians are plain and incontrovertible.

On Life Expectancy

Whilst a non-indigenous male born in 1997-1999 can expect to live for 77 years, an indigenous Australian male born in the same period can expect to live only **56 years**, a difference of 21 years. **This is equivalent to a non-indigenous Australian male born over 100 years ago.**

The figures for indigenous Australian females are equally poor. A non-indigenous female born in 1997-1999 can expect to live for 83 years, whilst

an indigenous Australian female born in the same period can expect to live only **63 years**. **This is equivalent to a non-indigenous Australian female born in the 1920s.**

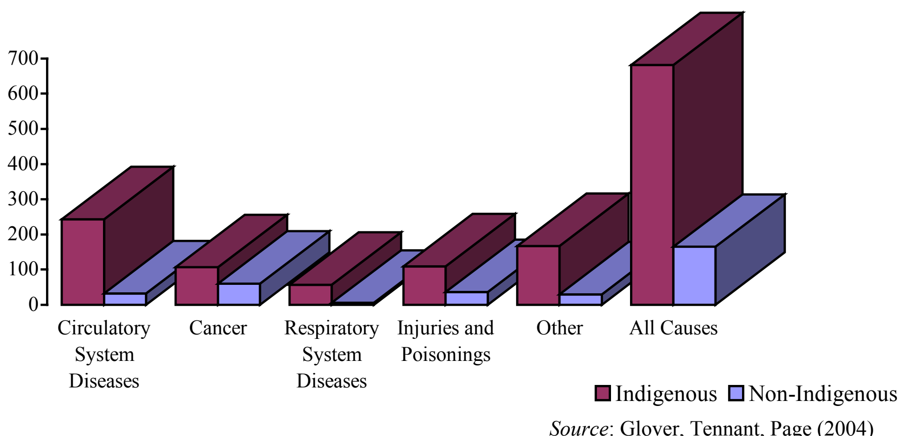
On Premature Deaths

The contrast between the health of non-indigenous and Indigenous Australians becomes even clearer when cause of premature death is considered. *Figure 2* groups causes of death into broad disease categories, comparing the rates of death between the two populations during 1997-99.

In 1997-1998, compared to other Australians, Indigenous Australians under the age of 65 were:

- 8 times more likely to die of coronary heart disease;
- 6 times more likely to die from stroke;
- 22 times more likely to die from diabetes;
- 8 times more likely to die from lung disease;
- more than twice as likely to die from intentional self-harm; and
- 6 times more likely to die as an infant.

Figure 2 : **Mortality Rates (per 100,000) by Indigenous status, 1997-1999 (0-65 years)**



Source: Glover, Tennant, Page (2004)

The Facts 2: Socioeconomic Disadvantage

For reasons that are becoming increasingly clear, poor physical and mental health are strongly associated with socioeconomic disadvantage. Good health and well-being are dependent upon a number of complex interdependent factors. These include, of course, adequate nutrition, shelter, and freedom from abuse and violence. Also important are meaningful employment and a sense of psychological security, generated through personal relationships and social networks.

Evidence from Australia and around the world has shown that a society characterised by large inequities in economic and social attainment experiences significant health inequities. In Australia, these inequities become apparent when comparing the health status of people living in advantaged areas with that of people living in disadvantaged areas.

One way of measuring this is to divide a specific region into small areas and to score them against an index consisting of variables indicative of relative advantage or disadvantage. In Australia, the Australian Bureau of Statistics (ABS) has constructed a series of such indexes, one of which, the Index of Relative Socioeconomic Disadvantage (IRSD), is regularly used to measure health inequities.

The results are striking.

During 1998-2000, by comparison with men (aged 25-64) living in areas of least disadvantage, Australian men (aged 25-64) living in areas of greatest disadvantage were:

- 2.1 times more likely to die of coronary heart disease;
- 1.9 times more likely to die of stroke;
- 2 times more likely to die from lung cancer;
- 2.5 times more likely to die from a liver disease;
- 2.8 times more likely to die from a respiratory disease (excl. lung cancer);
- 1.6 times more likely to die from suicide;
- 2.2 times more likely to die from a traffic accident; and
- subject to a 43% greater burden of mental disorder.

During the same period, by comparison with women (aged 25-64) living in areas of least disadvantage, Australian women (aged 25-64) living in areas of greatest socioeconomic disadvantage were:

- 2.7 times more likely to die of coronary heart disease;
- 1.8 times more likely to die of stroke;

- 1.7 times more likely to die from lung cancer;
- 2 times more likely to die from a liver disease;
- 2.4 times more likely to die from a respiratory disease (excl. lung cancer);
- 1.3 times more likely to die from suicide;
- 2 times more likely to die from a traffic accident; and
- subject to a 53% greater burden of mental disorder.

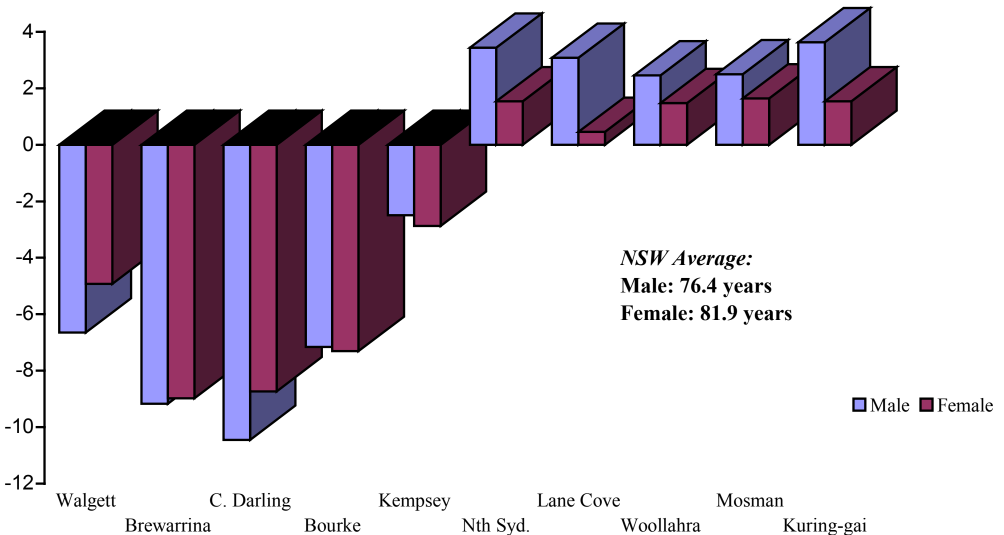
An Australian child from an area of greatest socioeconomic disadvantage compared with a child from an area of least disadvantage was:

- 1.5 times more likely to die as an infant (1997-1999); and
- 1.4 times (0-4 years) and 1.5 times (5-14 years) more likely to be hospitalised for asthma (2000-2001).

These higher rates of premature mortality have a striking impact on life-expectancy at the local level. ***Figure 3*** compares the respective life expectancies of people residing in the bottom and top five NSW local government areas (LGAs), ranked by level of disadvantage.

For 1998-2000, a man born in the rural Central Darling area of NSW could expect to live 13 years fewer than his compatriot born in Mosman, Sydney.

Figure 3 **: Life Expectancy at Birth (1998-2000): Difference in Years from NSW Average by Bottom 5 and Top 5 NSW LGAs ranked by IRSD**



IRSD = Index of Relative Socioeconomic Disadvantage

Source: Hoist Datasets (2004).

The Socioeconomic Gradient of Health

While the greatest difference in health status can be seen between the richest and the poorest, a health *gradient* exists across the whole population. In short, health status reflects socioeconomic status: the higher your position on the socioeconomic ladder, the better your health. Likewise the lower your socioeconomic status, the poorer your health.

Figure 4 shows the gradient across the quintiles of relative socioeconomic disadvantage for five common health indicators: child mortality rates, adult mortality rates, potentially avoidable deaths, 5-year survival rates for cancer and acute public hospital admissions. (Q1 is the least disadvantaged quintile and Q5 is the most disadvantaged quintile.)

Health Inequities are Increasing:

Although the overall health of Australians is improving, and the premature mortality falling, ***health inequities are growing***.

Figure 5 shows this by juxtaposing mortality rate ratios for 1985-1987 and 1998-2000. The growing inequities are seen for all-cause premature mortality, but are particularly evident in deaths from cancer and diseases of the circulatory system.

Excess Mortality: The Cumulative Effects of Health Inequities:

The cumulative effects of the socioeconomic gradient in health can be measured by the concept of ***excess mortality***.

Excess mortality is defined as the percentage of deaths which would be avoided if all people in the community enjoyed the same mortality rates as the least disadvantaged (i.e. those in the top 20% or Quintile 1).

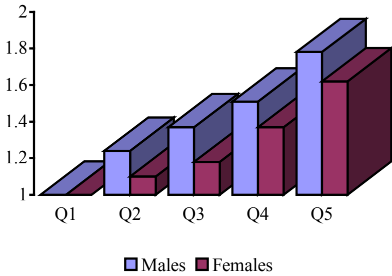
When applied in this way, excess mortality is a good indication of the percentage of deaths which are linked to social and economic inequality.

During 1998-2000, the excess mortality for males and females aged between 25 and 64 years was 29.6% and 20.3% respectively. **This translates into a total of 19,000 premature deaths attributable to socio-economic disadvantage.**

During 1998-2000, among boys and girls aged between 0 and 14 years, the excess mortality was 28.3% and 21.1% respectively. **This translates into almost 1,500 deaths among children attributable to socio-economic disadvantage.**

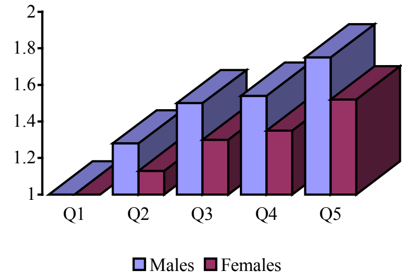
Figure 4: The Socioeconomic Gradient of Health

Age-standardised all-cause child mortality rate ratios (0-14 years) by IRSD, 1998-2000



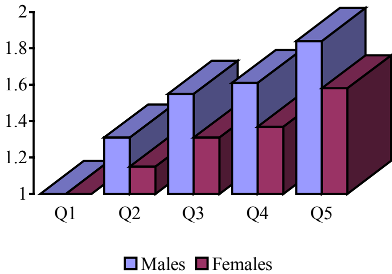
Source: Draper, Turrell & Oldenburg (2004)

Age-standardised all-cause adult mortality rate ratios (25-64 years) by IRSD, 1998-2000



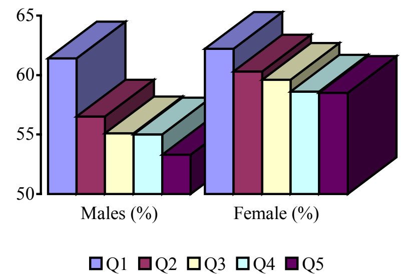
Source: Draper, Turrell & Oldenburg (2004)

Age-standardised 'potentially avoidable deaths' rate ratios (25-64 years) by IRSD, 1998-2000



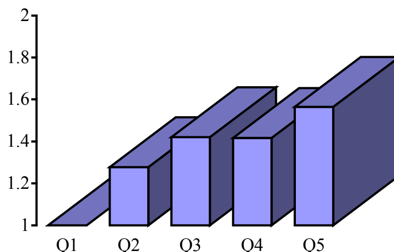
Source: Draper, Turrell & Oldenburg (2004)

5 Year Age-standardised survival proportions for all cancers: socioeconomic status & sex, 1992-1997



Source: AIHW & AACR (2003)

Rate Ratios: Acute Public Hospital Admissions by IRSD (1995-1997)

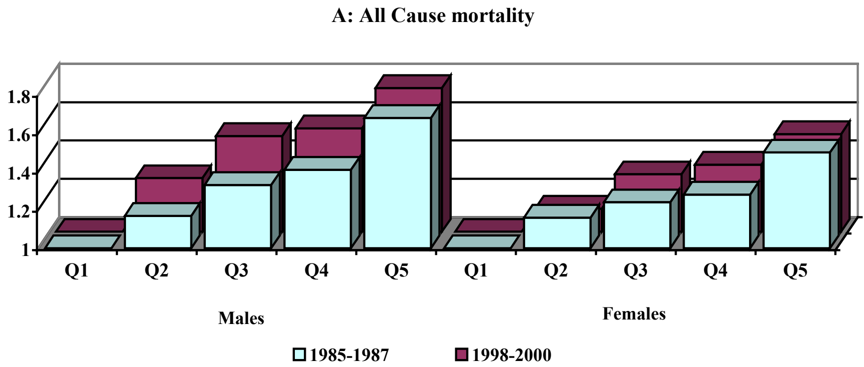


IRSD = Index of Relative Socioeconomic Disadvantage

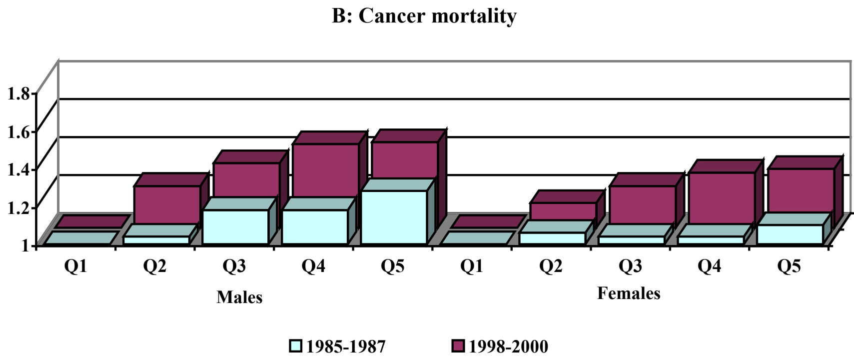
Source: National Social Health Atlas (1999)

***Figure 5*: Increasing health inequities: Age-standardised mortality rate ratios (25-64 years) by IRSD quintiles and sex, 1985-1987 and 1998-2000**

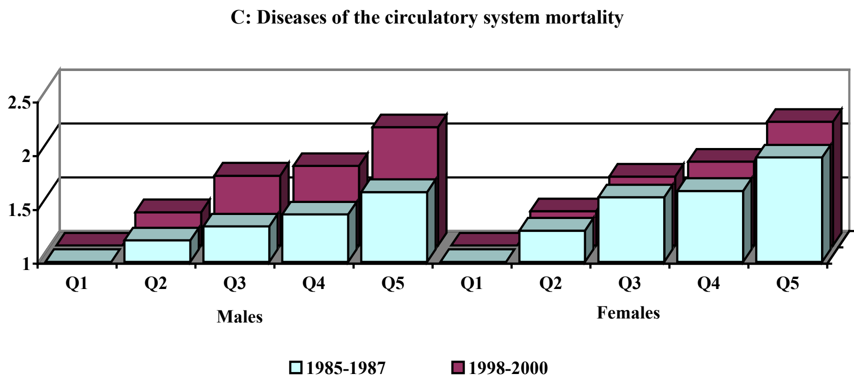
A: All Cause mortality



B: Cancer mortality



C: Diseases of the circulatory system mortality



Source: Draper, Turrell & Oldenburg (2004)

The Economic Cost of Health Inequities

Excess mortality figures are also important when estimating the economic burden of health inequities. Even ignoring the costs to the nation from lost productivity, the direct cost to the health care system is substantial. As health inequities are growing, not shrinking, they place serious pressure on the sustainability of the system.

Recent research by the *National Centre for Social and Economic Modelling* has put a dollar figure on the cost of health inequities to Australia. During 1998 savings of around $3 billion in health care costs and $1.2 billion in disability pensions would have been achieved had the health status of the whole population been equal to that of the most advantaged 20%. By 2018 the combined health and disability savings (in 1998 dollars) would amount to $5.0 billion per year.

Health Inequities & Health Care System Responsiveness

The evidence for the existence of health inequities in Australia is substantial and long-standing. The underlying causes of such disparities are complex, but include unemployment, low income, poor educational achievement and geographical location. A 'whole of government', private sector and community response will be necessary to address them.

The health care system itself, however, is an important contributor to the distribution of good health. The extent to which the utilisation of effective and timely health care reflects actual health needs is one way of measuring a health care system's contribution to health inequities.

Recent research in Australia suggests that the 'inverse care law' too often applies - the socioeconomically advantaged have disproportionate access to health care services relative to actual health and vice versa.

Recent OECD research into the equity of health service utilisation in 13 European countries has produced similarly worrying results. After accounting for actual health needs, general practice service utilisation exhibits a small but consistent pro-poor bias. Specialist services, however, are utilised disproportionally by the wealthy, with income and education rather than need being the best predictor of service use.

Typically, specialists deal with the more serious and complex of health conditions i.e. those conditions borne disproportionably by the socio-economically disadvantaged. The existence, therefore, of a significant pro-

rich bias in specialist service utilisation, even in countries with comprehensive and universal health care systems, is of concern.

As there are currently no Australian data on specialist service utilisation according to socioeconomic status, the implications from overseas research need to be considered as a matter of urgency by governments and by specialist medical bodies such as the College.

What can we do?

Too often we hear that little can be done to improve equity in health outcomes. **This is not true.**

In fact, evidence supports intervention at key stages throughout life to help promote a fair go for all. We know:

- that universal early childhood interventions are a key to better long term life outcomes;
- that reducing smoking by pregnant women would cut poor health outcomes for children;
- that improving access to quality education is a key to sustained health improvement and to breaking the inter-generational cycle of poor health; and
- that the 'inverse care law' must be tackled head on, with programs to improve access to and utilisation of health services by the most vulnerable.

What should happen?

What should governments do?

Governments in all jurisdictions are already moving towards integrated responses to health and social inequalities by 'joining up' activities across different departments. This should be encouraged and strengthened because health departments, by themselves, have little control over the underlying determinants of social and economic disadvantage.

However, it is not clear where coordination and leadership are provided on a 'whole of government' basis. The Department of Prime Minister and Cabinet and the Premiers' Department have a particular responsibility for policy coordination across the whole government system. In addition, given their role in shaping the socio-economic environment, Departments of Finance and

Treasury could make a much greater contribution and could become part of the solution.

To assist the re-orientation of public policy and programs to reduce health inequities, a rigorous approach should be adopted whereby all departments are called to account for their actions. A similar approach should be used as with the provision of Environmental Impact Assessments for changes in land use, building, mining etc.

Governments at all levels must introduce policies and programs and/or strengthen those that have been introduced to directly tackle health inequalities and the inequities they embody.

A simple example. *We know that*:

- smoking rates are disproportionately higher among disadvantaged people;
- smoking in pregnancy damages the developing foetus, being strongly associated with low birth weight and later learning problems; and
- respiratory infection and asthma are more common in children exposed to smoke at home.

We also know what to do. Well researched, evidence-based interventions to address smoking already exist. As a starting point, the focus should be directed toward pregnant women who smoke and the smoking parents of young children.

Recommendations:

(1) **That the Federal, State and Territory Governments make immediate commitments, both strategic and financial, to improving the quantity and quality of health care services in the poorest and most disadvantaged communities.**

(2) **That the Department of Prime Minister and Cabinet at the Commonwealth level and the Premiers' Departments at the State level be nominated as the accountable department for 'whole of government' responses to health inequities.**

(3) **That the Department of Prime Minister and Cabinet and the Premiers' Departments, as part of their leadership role, commission equity-focused Health Impact Assessments for all significant developments which could affect health inequities.**

(4) **That the Australian, State and Territory Governments consolidate a coordinated universal approach to early childhood promotion,**

prevention and early intervention activities to ensure that all children get a fair start in life. The Directors-General/Secretaries of all relevant Government departments such as Health, Community Services and Education should be made accountable for the achievement of key performance indicators related to the health, development and wellbeing of all children.

(5) **The Federal, State and Territory Governments should adopt targets to close the gap in realistic educational opportunities between different social groups. All Directors-General/Secretaries of Education should be made accountable for the achievement of key performance indicators.**

What should health care services do?

If further improvements in health status are to occur in Australia, the planning, development and delivery of health care services must focus on reducing health inequities. The availability of services should not exacerbate inequality. This is particularly important for Indigenous Australians, residents of rural and regional Australia and socially disadvantaged communities, especially regarding access to specialist medical services. Health services need to develop transparent and accountable strategies to reduce health inequities and to achieve optimum outcomes for groups most in need.

Recommendations:

(6) **That all health care organisations, at national, state, regional and local levels, develop explicit plans of action to reduce health inequities for the populations they serve and in the services they deliver.**

(7) **That all health care organisations make such plans publicly available and that they report annually on progress. This will require new and more appropriate information systems.**

(8) **That all health care service delivery and training organisations recognise the need for cultural competency in healthcare service delivery and include specific training at all levels of education and professional development.**

What the Royal Australasian College of Physicians will do

The RACP will contribute to reducing health inequities through training and education, standard setting and advocacy. For example, it will advocate for strong government leadership and review departmental responses. It will also advocate for improved services for high risk groups, such as Aboriginal and Torres Strait Islander Australians, people on low incomes, babies and young children.

Recommendations:

(9) That the RACP ensure that equity principles and an awareness of health inequities are included in the basic and advanced training, and continuing education of all physicians and paediatricians.

(10) That the RACP encourage and enable physicians and paediatricians to review their professional practice in the light of the evidence about health inequities and the need for action.

(11) That the RACP, when assessing the suitability of health care organisations for the training of doctors, consider the adequacy of their plans to combat health inequities.

(12) That the RACP ensure that an awareness of the need for cultural competence in the delivery of healthcare is fostered in the basic and advanced training, and continuing education of all physicians and paediatricians and advocate for such principles in the teaching of medical students.

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Annexure: The Royal Australasian College of Physicians

The Royal Australasian College of Physicians (RACP) was incorporated in Australia in April 1938.

The RACP has evolved to bring together different groups of physicians who share common ideals in medical practice. Physicians and paediatricians are medical experts to whom patients with complex and difficult or chronic diseases are referred. They emphasise the treatment of the whole individual within a social context. This requires not only a high level of medical expertise, but high cognitive competence and the ability to communicate exceptionally well with patients, other medical practitioners such as general practitioners, other health team members and medical trainees. These ideals have led the RACP to a unique position among the specialist medical colleges. Not only is the RACP the key professional training and education body for physicians in Australia and New Zealand, it has also emerged as a key informant and influence in health policy over a range of areas.

The RACP comprises over 8,000 Fellows, including Fellows of the College Divisions of Adult Medicine and Paediatrics & Child Health, and Fellows of the Faculties of Public Health Medicine, Rehabilitation Medicine, Occupational Medicine and of its Chapters of Palliative Medicine, Addiction Medicine, and Sexual Health Medicine. The Joint Faculty of Intensive Care Medicine is part of the RACP and the Australian and New Zealand College of Anaesthetists (ANZCA). In addition, the RACP encompasses a range of associated Specialty Societies representing the spectrum of practice in Internal Medicine and Paediatrics across 23 sub-specialties.

The core business of the RACP is focussed in four areas:

- promoting professional standards and patient safety through the broad areas of training and assessment;
- promoting, through continuing education, the maintenance of physicians' professional standards;
- promoting, through research and dissemination of new knowledge and innovation to the profession and in the community, the knowledge base of physicianly practice and the science of medicine;
- promoting, through the development of health and social policy and its advocating in partnership with health consumers, health outcomes for all Australians.

The RACP's core business is the provision of the training infrastructure in cognitive and procedural practice, and in public health, through curriculum development and assessment, for the majority of consultant physicians working in high volume and high cost areas of medicine.

As it has grown and evolved, the RACP has developed a broader interpretation of its Mission Statement The RACP has become involved in, and taken a leadership role in, health and social policy, in quality improvement programs, and in the integration of outcomes through education and curriculum development. These in turn influence and enhance training experiences at all level, including continuing education.

The RACP comprises medical consultants committed to providing the highest quality of care in internal medicine, in paediatrics and in their sub-specialties, for the people of Australia and New Zealand.