Social Determinants of Health and the Prevention of Health Inequities

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Definitions

Social Determinants of Health - Social determinants are the social and environmental conditions in which people live and work.

Health Inequalities - Health inequalities mean that some people die younger or have poorer health based on where they live, their genetics, the job they do, or how much their parents have earned. Interventions to address inequalities can be referred to as occurring upstream, midstream or downstream. Upstream determinants are those that occur at the macro level and include global forces and government policies. Midstream determinants are intermediate factors such as health behaviours while downstream determinants occur at the micro level and include one's genetics[1].

Health Inequities – are those inequalities that are avoidable.

Equity - Equity can be considered as being equal access to services for equal need, equal utilisation of services for equal need and equal quality of care or services for all. Central to this is the recognition that not everyone has the same level of health or capacity to deal with their health problems, and it may therefore be important to deal with people differently in order to work towards equal outcomes.

Healthy Public Policy - Involves the development and implementation of public policies such as those relating to transport, employment and environment, which do not originate in the health portfolio, but take into account the health implications in the policy in a way that is positive for health.

Introduction

Australians generally have good health. Australia is consistently ranked in the top 10 of OECD nations in many areas, including life expectancy and mortality rates[2]. But many Australians, particularly Aboriginal peoples and Torres Strait Islanders and people who are socio economically disadvantaged suffer poor health compared with the rest of the population. In these cases, there are profound health and life expectancy inequities. It could be argued that the extensive health and social inequities experienced by Indigenous Australians overshadow the inequities experienced by other population groups in Australia.

The social determinants of health have always been important to health. They underpinned much of the early public health with its focus on living conditions. Prior to the development of effective medications and other measures it was only the social determinants that could be influenced to improve health. However, with improvements in medication and specific treatments for specific diseases, coupled with an increasing political focus on individuals and their locus of control, social determinants have not always been at the forefront of ways to influence and improve health.

In order to decrease health inequities, it is critical to not only include treating diseases and modifying risk factors (such as smoking) but also to increase the focus on the social determinants that make these risk factors and subsequent diseases more prevalent. In addition this position statement recognises that there is a role for individual responsibility in determining a person's health.

There are large economic costs associated with health inequalities. The National Centre for Social and Economic Modelling estimated that, in 1998, $3 billion in health care costs and $1.2 billion in disability pensions would have been saved if the health status of the whole population was equal to that of the most advantaged 20 per cent. The Centre estimated that, by 2018, the combined health and disability savings would grow to $5 billion per year.

Countries that have fewer income inequalities also appear to have lower mortality rates. Also countries that prioritise redistribution of income through fiscal and social policy have lower health inequalities and better overall population health than those that do not[3].

As societies with high levels of income inequality tend to have more violent crime and less social cohesion addressing health inequities is important to all of us. In their 2005 document, Inequity and Health: A call to action, the Royal Australasian College of Physicians identified health inequities as one of the most pressing problems currently facing Australia.

What are the Social Determinants of Health?

Social determinants are the social and environmental conditions in which people live and work, and include the following:

The Social Gradient
A person's social and economic circumstances affect their health throughout their life. A social gradient of health runs across society and, while the most profound differences in health can be seen between the most and least disadvantaged, a gradient exists across the population in which, for example, those in the upper middle of least disadvantage will have better health than those in the lower middle of least disadvantage[4].

Disadvantage has many forms and can be absolute (eg not having access to education or unemployment), or relative (eg poorer education, insecure employment). Each of life's many transitions - such as leaving school, getting a first job - can affect health by moving people onto a more advantaged or less advantaged path. People who have been disadvantaged in the past are at greater risk in every subsequent transition. Disadvantages tend to congregate among the same people and their effects tend to accumulate through life and are passed on from generation to generation[4].

Stress
Social and psychological circumstances can cause long-term stress and be damaging to health, and may lead to premature death. Continuing anxiety, insecurity, social isolation, and lack of control over work and home life are examples of such stressors. As well as contributing to poor mental health, the inappropriate and regular activation of the body's stress response impacts negatively on the cardiovascular and immune systems. While not a concern in the short term, in the long term these feelings of stress make people more vulnerable to conditions such as infections, obesity, diabetes, hypertension, stroke and depression. In industrialised countries, these conditions are more common in people who live in the lower levels of the social hierarchy[4].

Early Life
It is now well understood that the foundations of adult health are laid down before birth and in early childhood. Slow growth and poor early experience become biologically embedded during development. They increase the lifetime risk of poor emotional health and reduce physical cognitive and emotional functioning into adulthood.

Poor experiences during pregnancy such as nutritional deficiencies, maternal smoking, alcohol and drug use, and inadequate prenatal care can lead to poor foetal development, which is a risk in itself for poor health later in life[4].

Social Inclusion / Exclusion
Poverty (absolute and relative) has a major impact on health and premature death. Poverty denies people access to full participation in the life of the community. In the international context, those who are homeless have the highest rates of premature death.

Social exclusion also results from racism, discrimination, stigmatisation and unemployment. The greater the length of time that people live in disadvantaged circumstances the greater the risk for ill-health, particularly cardiovascular disease. As people move in and out of poverty during their life, the prevalence of people who have experienced social exclusion (and its negative impact) is greater than the current incidence[4].

Education
Generally, those with the lowest health status also have low educational and literacy levels. Poor education means a person is less likely to attain secure and well paid employment and this can lead to poverty and other predictors of ill health.

Employment / Occupation
As a general rule, having a job is better for health than being unemployed. However stress at work increases the risk of disease. Jobs that are demanding and where employees have little control or decision making in their employment are the most detrimental to health. Improved work conditions will lead to a healthier workforce, which will, in turn, improve productivity and decrease absenteeism[4].

Occupation is often used as a measure of socio-economic status. Those in 'blue collar' occupations have poorer health status across almost all indicators compared with those in professional/managerial occupations[1].

Unemployment
People who are unemployed, and the families of those who are unemployed experience a much greater risk of premature death. These risks are higher in regions where there is widespread unemployment and when the risks relate to the psychological and financial (particularly debt) effects.

The health effects begin when people first feel their jobs are under threat, prior to becoming unemployed. Job insecurity or very unsatisfactory employment can be as harmful as unemployment, with increasing effects on mental health, heart disease, and the risk factors for heart disease[4].

Earnings / Disposable Income
Adequate income affects one's ability to have safe housing (including appropriate plumbing and infrastructure, no overcrowding and a location away from violence) and ability to buy sufficient quality food and health care. After a certain income there is no longer a correlation between increased income and increased health. However, the health benefits of increased socio-economic status become smaller as socio-economic status increases[4].

In the past 20years, income inequality has been increasing in Australia. As an example, between 1994-95 and 1998-99 there was a 20 per cent increase in the taxable income of Australians. However, the poorest postcodes achieved an increase of only 16 per cent whereas the wealthiest postcodes achieved an average increase of 25 per cent.

This trend also exists internationally within and between countries with income inequality increasing in nearly all countries since the 1980s. Income inequality is higher in the United States of America than in Nordic countries such as Sweden.

Social Support
Social support and social relations give people emotional and practical resources as well as a sense of mutual respect where people feel loved and valued. All these aspects have a protective effect on health and provide a buffer against health problems. Without them people are likely to experience less well-being, more depression, and higher levels of disability from chronic diseases.

At the societal level, social cohesion (the quality of social relationships and the existence of trust, mutual obligations and respect in communities) helps to protect people and their health. Societies that have high levels of income inequality tend to have less social cohesion and more violent crime[4].

Addiction
Alcohol and smoking dependence and illicit drug use are both responses to social breakdown and significant contributors to further escalation of health inequities. Often people turn to alcohol and other drugs as a way of reducing the pain of harsh social and economic realities. Unfortunately, apart from a temporary release, these substances only intensify the factors that lead to the use in the first place. These substances are a large drain on people's incomes, reduce participation in society, and are a large cause of ill-health and premature death[4].

Food and Nutrition
Food security is an important issue in parts of Australia and internationally. Food poverty can exist side by side with food plenty, while access to good quality food makes a greater difference to what people eat than nutritional education. Generally, people on low incomes - such as young families, elderly people and those who are unemployed - are least able to eat well[4].

In Australia, there is a particular issue with food security for isolated Aboriginal and Torres Strait Islander communities. Fresh fruit and vegetables must be carried many hundreds of kilometres, often in un-refrigerated, trucks and much of the nutrient value of the food perishes in the journey. Once it arrives at the local store, it may or may not be able to be stored in conditions to maximise the nutrient value and it is definitely many times higher in cost than what would be paid in urban areas. Often there is also not the appropriate kitchen and cooking facilities to be able to prepare the fresh food into proper meals.

Under nutrition can lead to susceptibility to disease in addition to specific disorders. An increase in food and fluid energy intake (particularly with a energy dense of high sugar content) is a factor in the development of obesity which is increasing rapidly in prevalence.

Some studies have shown that more affluent areas more likely to not have take away food stores. This implies that there is the market in less affluent areas for cheap take away type food.

Transport
Cycling, walking and use of public transport promote health through exercise, reducing accidents and air pollution, and increasing social contact. People without private transport and people in places with poor or no public transport are less able to participate fully in the life of the community and its concomitant health impacts[4].

Race and Culture
There are some differences in the burden of disease between races that are determined by genetics. But the issue that has the greatest impact on equity in health outcomes is racism whether it is at an individual level or institutionalised. Institutional racism refers to the ways in which racist beliefs or values have been built into the operations of social institutions in such a way as to discriminate against, control and oppress various minority groups. It has been argued that institutional racism is embedded in Australian institutions. Often, institutional racism is covert or even unrecognised by the agents involved in it.

Racism can affect diagnosis and treatment and therefore health outcomes.

Disability
This can include physical/mental/emotional disabilities. Those with disabilities are more likely to be living in poverty and experiencing social exclusion than the general population.

Criminal Records and Incarceration
In *A Public Health Perspective on Cannabis and Other Illegal Drugs,* the Canadian Medical Association highlights the profound impact on heath status associated with having a criminal record. The presence of a criminal record can severely limit employment prospects leading to poor health. Prisoners also require equity in access to health services given their burden of disease.

People with a criminal record are less likely to be employed. or more likely to employed in lower skilled or temporary work[4].

Responses by the Health System to the Person with Disease
This is where the AMA can make the greatest impact through its own membership and through that develop the greatest integrity and authority to advocate and campaign beyond its borders'. It can be argued that all health practitioners have a responsibility to address equity in their work.

While upstream and midstream determinants influence the type, likelihood, number and severity of diseases that affect a person, downstream inequities come into play when a person becomes ill. They are at many levels:

1. Access to primary care medical practitioner –fewer doctors in lower socio-economic areas;
2. Attitudinal barriers – 'they don't help themselves';
3. Medical system 'less foreign' or intimidating for those from higher socio-economic groups;
4. Less optimal form of treatment;
5. More likely to get medical as opposed to surgical intervention for a problem; and
6. Less likely to be referred to rehabilitation services.

People from higher socio-economic groups are more comfortable standing up for their rights, more able to educate themselves on their condition and challenge or ask doctors for specific treatments (all assist in being able to work in partnership with their doctor).

Often these inequities are made invisible under the guise of treatments decisions eg risk of poor outcomes due to multiple other health problems; complicated lives; lack of transport etc to keep appointments; challenging treatments such as transplant and lack of carer support therefore encouraged 'just to have chemotherapy'.

The AMA Position on Social Determinants and Prevention of Health Inequities:

1. The Australian Medical Association calls on Governments to make the first priority in addressing health inequities in Australia the improvement of Aboriginal and Torres Strait Islander peoples' health until their health outcomes and life expectancy equal that of other non-Indigenous Australians. This is a human rights issue and Australia's greatest shame.

2. The Australian Medical Association calls on governments to improve the quantity and quality of services to those in the poorest and most disadvantaged communities and make such services accessible to the resident populations. The AMA calls on the government to do this as a human rights issue.

3. The Australian Medical Association calls on governments to recognise that while addressing health inequities is a human rights issue, doing so is also cost effective in the long term.

4. The Australian Medical Association calls on Governments and politicians of all parties to speak openly about the importance of social determinants of health and the health inequities that exist in Australia, and put them higher on the government agenda. It is time for a public debate on health inequities and immediate interventions to reduce them.

5. The Australian Medical Association calls on Governments to make health outcome equity the explicit goal of all public policy – health education, employment, housing, economic. The AMA calls on government for initiatives with the explicit intent of reducing health inequities. All current and future policies must be assessed according to their impact on health and equity. Governments must stop policies and funding decisions that exacerbate inequities. Systems must be established to monitor for unintended consequences of policies that may increase inequality.

6. The Australian Medical Association calls on the government to make research into effective interventions to reduce inequities a priority area for the National Health and Medical Research Council and Australian Research Council research. While monitoring changes in levels of inequality is important and necessary, priority must be given to research that identifies and evaluates interventions to reduce inequities.

7. The Australian Medical Association calls for a whole of government response to health inequities to be the responsibility of the Council of Australian Governments (COAG). Targets in reducing inequality would be set and regular reported against at COAG meetings. Prime Minister and Cabinet and the Premiers departments at state level should have carriage of, and be responsible for, initiatives to address inequities in the social determinants.

8. The Australian Medical Association calls on governments to develop a universal approach to evidence based early childhood promotion and prevention and early intervention programs to ensure every child has the best start in life, as is their human right, and to provide funding to match.

9. The Australian Medical Association calls on government and bureaucracies to recognise and eliminate institutional racism. This is imperative in order to reduce inequalities based on race.

10. The Australian Medical Association calls upon all State and local health authorities to have explicit indicators of inequities in their population and commit to reducing them. These should be publicly available and reported against annually.

11. The Australian Medical Association calls for policies addressing education, employment, poverty, housing, taxation and social security to be assessed for their impact on health.

12. The Australian Medical Association calls on governments to adopt targets to close the gap in educational opportunities and outcomes between different social groups. Heads of education should be responsible for adopting and meeting the targets.

13. The Australian Medical Association believes that as the nature of work changes and evolves, governments should ensure access to retraining and reemployment schemes. Employment contracts should provide security of employment and 'quality living' conditions.

14. The Australian Medical Association calls for approaches to the food system to ensure affordable and nutritious food for everyone, particularly the most vulnerable.

15. The Australian Medical Association believes there are adverse health impacts associated with criminal records and prison sentences and that these health impacts should be taken into account in the development and review of public policy and legislation.

16. The Australian Medical Association calls on Government responses to licit and illicit drug misuse to include policies and interventions that address the underlying social conditions and experiences that give rise to drug use.

17. The Australian Medical Association encourages doctors to regularly reassess their own practices to ensure that their treatment decisions contribute to improving health equity for both individuals and communities. The Australian Medical Association encourages doctors to be passionate and informed advocates for equity and to be mindful of the social determinants that are in play in a patient's life during consultations.

18. The Australian Medical Association encourages medical colleges and professional societies to increase their members awareness of health inequities in general, and potential bias in medical treatment decisions. This can be done by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curricula, in medical journals, at professional conferences, and as part of professional peer review activities.

19. The Australian Medical Association encourages those involved in medical education to develop and implement policies that support the entry and completion of medical studies by students from disadvantaged groups.

20. The Australian Medical Association encourages those involved in developing practice and clinical guidelines that reduce health inequities to recognise and support the needs of disadvantaged groups.

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