VALUING EQUITY

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Population Health Planning Framework

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Why population health planning is concerned with health inequity

Australians generally enjoy good health, especially when compared to the populations of many overseas countries. However, these aggregated statistics often conceal the fact that some groups and neighbourhoods in our society consistently experience poorer health that others. These groups are more likely to suffer from preventable diseases, (in particular chronic diseases, obesity, some cancers), and injury, be exposed to risk factors, and live shorter lives (VicHealth 2005).

In order to improve the health of *whole* populations, population health planning responds to the differences in health opportunities, access, and outcomes which result in health inequalities. Population health planning, therefore, seeks to reduce avoidable inequities.

Health inequalities and inequities

Health *inequalities* are differences in health outcomes or opportunities that arise between groups, (eg, higher rates of heart disease among indigenous populations compared to other Australians).

Health *inequities* are **unnecessary and avoidable health inequalities.** Differences in health status may result from different living conditions, such as reduced access to nutritious foods, poor housing, and inadequate access to healthcare, lower income levels, stressful work conditions, and frequent periods of prolonged unemployment, and these are the result of inequities (DH 2012). Inequities are considered **unfair and unjust** (Whitehead 1992) because people don't have the same opportunities to make choices, access health services, and experience conditions conducive to health.

Types of inequality

The VicHealth report *People, Places, Processes* (2008) presents three dimensions to inequality:

1. **Inequality of access**
2. **Inequality of opportunity**
3. **Inequality of impacts and outcomes**

Health and community services can address *inequality of access* (mainly understood as cost, cultural barriers such as language translation, physical modifications, and culturally appropriate service delivery). However, of equal importance is action to address *inequality of opportunity,* (such as education, income, and employment), and measuring *inequality of impacts and outcomes,* (by collecting data that analyses the different impacts and outcome for sub-populations).

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Health Inequalities in Australia

Population groups within Australian commonly identified as experiencing poorer health outcomes include (VicHealth, 2005):

1. **Aboriginal and Torres Strait Islander people**. Health inequalities are most marked between Indigenous and non-Indigenous Australians. Aboriginal men and women have a life expectancy 17 years lower than the national average.
2. **Socioeconomically disadvantaged people** generally have poorer health than their more advantaged counterparts, with health status generally improving along the social gradient.
3. People living in **rural or remote areas**.
4. Some groups of **migrants, refugees, asylum seekers**. Recently arrived refugees have relatively poor health status, resulting from exposure to deprivation, human rights abuses, conflict and violence in their countries of origin, and asylum and the stresses involved in establishing life in a new country.
5. **People with disabilities** (as a group) tend to report poorer perceived health status, with ratings of health declining with greater degrees of disability.
6. **People with a mental illness.** People with mental illness experience poorer health outcomes than the mainstream population. Multiple risk factors, (eg, alcohol and drugs, food insecurity), combined with a lack of protective factors (eg, childhood experiences, income), can predispose a person to the development of mental illness

It is important to note that disparities in health outcomes can also be related to geographic areas.

> "…people may experience poorer health in part because they live in environments which do not support good health, (eg, without accessible, cheap and healthy food; safe streets; recreation facilities; and opportunities for meaningful social participation).
>
> (VicHealth 2005:20)

The social gradient of health

In most countries, an individual's socioeconomic status is the most influential determinant of their health (Brown & Nepal, 2010). Wealth does not just provide access to health services but influences other known determinants of health, such as education, employment, housing tenure, and social connectedness (Brown & Nepal, 2010).

> "It is a well-known fact that position on the social ladder affects life expectancy and the prevalence of most diseases. Each step up the social ladder of income, education, or occupation improves health status incrementally. This fact is called the 'social gradient' and applies across the population."
>
> (The Allen Consulting group 2008:8)

The '*Closing the Gap'* Report (CSDH 2008) by the WHO Commission on Social Determinants of Health highlighted the dramatic social gradients in health that exist within most countries. In Australia,

health inequalities associated with the social gradient of health are also well-documented, and are the focus of many state and federal government initiatives, such as:

- *COAG's Closing the Gap initiative*
- *Health lies in wealth; health inequalities in Australians of working age* (2010), Catholic Health Australia
- Victorian Government's *Prevention Community Model*
- Victorian Government's *Fairer Health; case studies on improving health for all* VicHealth has produced multiple publication on health inequalities
- *Implementing Health in All Policies* (2010)- an initiative undertaken by the Government of South Australia and the World Health Organisation
- *Pathways to Social Inclusion, proposition papers* (VICSERV). This document addresses health inequalities for people with a mental illness.

Valuing equity

A population health approach to planning is underpinned by a value of equity. The Public Health Association of Australian (PHAA 2012) identifies six reasons to reduce health inequities:

1. **Health inequities are unjust** as they are generally not biological, but are determined by factors which are largely outside the control of the individual and are potentially avoidable.

2. **Health inequities are avoidable and amenable to change**. Shifts in socioeconomic conditions can change the health of populations in the short term, both positively and negatively.

3. Because of the socioeconomic health gradient, **virtually everyone's health can be improved if inequity is reduced.** (This population-wide benefit is demonstrated in the award-winning book *The Spirit Level; why equality is better for everyone* ,Wilkinson and Pickett, 2009).

4. **Health inequities arguably affect everyone's health and wellbeing**. The excessive burden of health and welfare problems such as infectious disease, alcohol and other drug misuse, mental illness, housing insecurity, and violence in disadvantaged groups also has adverse health and social impacts on all sectors of society.

5. There are **major economic impacts of social and health inequities**. Excess morbidity and mortality directly attributable to disadvantage is a major economic burden, in terms of increased health and social costs and reduced economic productivity. Programs to reduce health inequity can be cost effective and may be promoted on efficiency grounds. Addressing health inequities will also help address the currently increasing burden of chronic lifestyle diseases by assisting in the achievement of key health promotion and preventive health goals.

6. There is evidence that some relative **health inequities may be increasing**. Overall improvements in population health status may obscure the relative lack of improvement or deterioration in the health of some groups, for instance, Aboriginal populations.

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Population health planning questions why some groups are healthier than others and seeks to make health outcomes more equitable for populations. Organisations that apply a population health approach to planning need to include equity as a desired outcome of planned actions.

Health for all, not just for some

Approaches that focus on at-risk behaviours can be more effective among people of higher socioeconomic status (Frohlich et al 2008), which can have the effect of either maintaining or increasing health inequalities. A vulnerable population approach seeks to alleviate the causes of vulnerability which are rooted in the social determinants of health. If only vulnerable groups are targeted, the health status of the rest of the population may worsen if neglected. In providing health for all, population health planners must find a balance between addressing vulnerable groups and population-wide approaches that address health issues across the social gradient. Both approaches are needed in a population health approach to planning.

It is essential that health outcomes for whole populations and for vulnerable groups are monitored and evaluated in population health action. Frohlich et al explore the challenges and need for balance between these approaches in their article *The Inequality Paradox: The Population Approach and Vulnerable Populations* (2008).

Taking action to reduce health inequities

VicHealth (2005:10) proposes four levels at which unjust or avoidable health inequalities can be addressed through action on socioeconomic determinants of health. These are:

1. taking steps to reduce inequalities in power, prestige, income and wealth
2. reducing the effect of health on socioeconomic position, (eg, by providing benefits and supports to people in poor health)
3. reducing the risk of negative impacts of social and economic disadvantage on health, (eg, through the provision of good public housing for low income earners)
4. reducing the health effects of low socioeconomic status, (eg, through providing good quality and appropriate primary healthcare)

Suggested reading

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