Report documents health impact of social inequality in Australia

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A little-publicised report released in Australia last month has provided conclusive evidence that deep-rooted social inequality is responsible for wide gaps in the health, well-being and life expectancy of people of working age. The *Health lies in wealth* report, prepared by the National Centre for Social and Economic Modelling, found that one's health is principally determined by wealth.

The data, compiled for Catholic Health Australia (CHA), demonstrates that health differences go far beyond unequal access to medical care, which has previously been regarded as the primary reason why the rich live longer. In the words of the report, far more important are the "social determinants of health", notably household income, level of education, employment and housing tenure.

While the report deals only with "working age" people (aged 25 to 64), it provides an array of evidence that the poorest sections of the working class have the worst health, often markedly so.

Mortality rates are revealing. The mean number of deaths per 100,000 people in these age brackets rises significantly upward from the wealthiest 20 percent of the population to the poorest 20 percent, with the poorest working-aged people suffering more than twice the number of deaths as the richest. The social and personal costs are immense. If the most disadvantaged local areas had the same death rates as the most advantaged, then between a half and two thirds of premature deaths would be prevented.

Information at the personal level is scant, so only area averages are possible. Using Australian Bureau of Statistics local area data from one state, Victoria, a male born in the poorest area would expect to live 3.5 years less than if born in the wealthiest area. For women, the difference is 2 years. This conclusion is supported by a national study from the Australian Institute of Health and Welfare, which found that people from the poorest quintile would expect to live over 4 years less of healthy life.

This pattern is in line with the results of studies undertaken elsewhere in the world. In England, for example, it was found that the life expectancy of people in the richest neighbourhoods was seven years more than that of people from the poorest areas. Because these estimates are based on area death toll totals, they are likely to understate the life expectancy gap between the wealthiest and most disadvantaged individuals.

Health lies in wealth found that those who are most socio-economically disadvantaged are twice as likely as those who are least disadvantaged to have a long-term health condition. Men in the 25-44 year old group in the bottom quintile or living in a jobless household are 4 to 5 times more likely to suffer such a condition. Between 45 and 65 percent of all people who live in public housing reported chronic health problems (the percentages increase with age) as opposed to 15 to 35 percent of home owners.

The cumulative effect of poverty on health is shown clearly in the health of older workers. For women aged 25-44, some 78 percent in the bottom quintile reported good health, in comparison with 92 percent of the wealthiest. But in the 45-64 year-old group, only 53 percent of women reported good health from the poorest group, compared with 86 percent of the wealthiest. Just 45 percent of women in this older group who rent in public housing reported good health. Figures for men show similar trends.

Health lies in wealth also helps puncture the official myth that so-called life style choices, such as smoking, alcohol consumption, obesity and physical inactivity, lie at the heart of the gulf between the health of the wealthiest and poorest members of society. In reality, these "risk factors" arise from economic deprivation, financial pressures and the resulting personal and family stresses, which start from birth and are magnified by unequal access to educational opportunities.

Although the report does not probe the sources or causes of the basic social inequities, it emphasises that unequal health outcomes cannot be explained simply by "unhealthy behaviour" or difficulties in access to health care, but result from a "toxic combination" of government policies and "unfair economic arrangements".

The report states: "Individuals are conditioned, constrained and pressured by the environment in which they live." The traditional "risk factors" are referred to as "proxy measures" that arise out of "underlying socio-economic disadvantage". In releasing the report, CHA chief executive Martin Laverty commented that "completing school better predicts if you are likely to die of cardiovascular disease, than cholesterol levels,

blood pressure, and smoking combined."

Wealth levels largely determine factors such as smoking, drinking, diet and physical activity. Some 20 percent of the adult population smoke, but two-thirds of women aged 25 to 44 who live in public housing are smokers. Men from 25 to 44 are nearly 4 times as likely to be a smoker if they left school before year 12, compared with those who have a tertiary qualification. This educational difference also makes a young man up to twice as likely to being a high risk drinker. Younger women are over 3 times as likely to be obese if they live in public housing compared with those owning their home.

The starkest expression of the effect of poverty on health is the low life expectancy of the indigenous population. An indigenous man can expect to live 11.5 years less than a non-indigenous man, and for women the gap is nearly 10 years. The report's findings show that this indigenous "gap" is part of a broader gap—one based upon class and socio-economic disadvantage.

The report confirms the results of previous studies internationally, including by the World Health Organisation (WHO). A 2008 WHO report, by the Commission on Social Determinants of Health, stated: "These inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces … Social injustice is killing people on a grand scale."

Because of the serious implications of its findings, *Health lies in wealth* has been buried by the media and Prime Minister Julia Gillard's government. Brief reports appeared in some media outlets on the day the report was released, with no discussion of its social and political significance, and there has been nothing since. Health Minister Nicola Roxon paid lip service to the report in parliament when reintroducing the Labor government's legislation to establish an Australian National Preventive Health Agency.

Roxon said the new agency would have an opportunity to "strategically assess the social determinants of health" as shown by the report. But the central thrust of her remarks, and the overwhelming focus of the $130 million set aside for the agency's research and "social marketing" programs, was to blame alcohol, tobacco and other substance abuse, and obesity, for a "rising incidence of chronic illness".

Moreover, Roxon declared that convincing people to "change lifestyles" was critical to the government's efforts to make the health and hospital system "sustainable in the long term" and ensure that Australia's "productive capacity is maintained".

The new Labor minority government has been given the task of driving down health spending, imposing other austerity measures and boosting corporate profitability, which will only worsen the inequalities. Briefing documents prepared for the government by the Treasury and Finance departments have recommended a series of deep cuts to public health, aged care, public sector jobs and welfare, including aged and disability pensions.

Among the immediate recommendations are a curtailment of the Pharmaceutical Benefits Scheme (PBS), which subsidises selected medicines and drug treatments. The inevitable outcome will be to confine the most expensive and best available treatments to those wealthy enough to be able to afford their full market price, leaving the working class and poor further exposed to protracted illness and financial stress.

Under the banner of "health reform", the Labor government has proposed a market-based "casemix" funding model for hospitals, which is designed to ration health care according to an "efficient" price and force hospitals, public and private, to compete to generate cost savings. The most chronically-ill patients, whose treatments require the greatest expenditure and resources, are the ones most likely to suffer from the resulting budgetary pressures.

The government's entire program seeks to make the working class bear the burden of the global economic breakdown. The financial crisis is also being used to drive down working and living conditions, producing higher levels of unemployment, under-employment and job insecurity, as well as lower wage rates. These measures will only intensify the social hardship and inequality that lie at the root of the profound health "gap".

One of the most essential social rights in contemporary society is to live free of poverty and material want, and the curse of debilitating ill-health that goes with them. The data compiled in the *Health lies in wealth* report demonstrates that capitalism and its political servants are totally incapable of meeting this fundamental need.

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