**HSC Option 5 – Equity and Health**

* **Why do inequities exist in the health of Australians?**
* **Factors that create health inequities**

**Daily living conditions**

* People in poor living conditions are at greater risk of contracting and spreading communicable diseases
* The socioeconomically disadvantaged and the elderly can find themselves renting or occupying housing that is older and run down. These conditions contribute to a higher incidence of respiratory disease, especially asthma
* Older dwellings are more likely than newer buildings to need costly maintenance e.g. plumbing
* Socioeconomically disadvantaged individuals who cannot afford adequate insulation or safe heating in homes are often the victims of injury or deaths related to burns
* Living in confined/crowded areas increases the possibility of stress-related illnesses and there is a greater potential for domestic violence or abuse

**Quality of early years of life**

Genetic and environmental factors

* Genetic material from parents may increase or decrease the risk of developing a particular disease.
* Mothers can also pass on effects of drug use and other life style behaviours
* Young children exposed to passive smoking in home environment are at greater risk of respiratory illnesses
* Air quality, noise pollution and safe water supply all impact on early years

Socioeconomic status of parents

* Higher income households can afford private health care and are able to gain easier access to diagnostic testing and treatment for young children who experience ill health
* Common for people from lower socioeconomic backgrounds to not immunise their children for infectious diseases which can spread through the community and delay the development of other young children e.g. whooping cough
* Ability to afford nutritious foods, adequate housing or access to GP’s is affected by socioeconomic status
* People from low socioeconomic backgrounds tend to eat a higher proportion of takeaway meals that are high in fat and rich in kilojoules

Sociocultural factors in the early years

* Food, water, clothing, shelter, love, security = strong family structures
* Some cultures have strong family support structures, with the older relatives and siblings taking care of the young when both parents have to work
* Some families cannot provide this level of support. Children may spend more time with friends or in day cares as parents work

**Access to services and transport**

* To have access to health services, there must be a good infrastructure and an awareness in the community of the care available
* Elderly may find difficulty travelling to specialists, especially if socioeconomically disadvantaged or disabled. Infrequent transport services hinder reliability of these services
* Rural and remote areas rely on health care provided on a rotational basis or on telemedicine (phone, internet, and videoconferencing). They have the greatest disadvantage in access
* Non English speaking migrant groups may be unaware of important health promotion initiatives expressed in mass media. Essential to use community newspapers
* Migrants find difficulty in finding doctors who speak their language.
* Reluctance of indigenous people to seek ‘traditional white medicine’ comes from past distrust/language barriers
* Those without health insurance have to go on waiting lists for public hospital treatment, so access to services may be delayed

**Socioeconomic factors**

People of low socioeconomic status

* Tend to have a poor attitude towards maintaining their health
* Most likely to use primary or secondary health facilities (doctor, hospital) rather than a preventative health service (immunisation, dental check-ups, breast screening)
* Can be caught in poverty traps caused by generations of unemployment
* Attitudes passed down through family contribute to devaluing work and education of youths
* Tend to adopt unhealthy behaviours: smoking, excess alcohol consumption, high-fat diet, irregular eating patterns, physical inactivity
* Life expectancy is 35% lower than higher socioeconomic groups
* Less able to buy medicines to treat minor illnesses
* Nutritionally low diets lower their immunity to many infections

People of higher socioeconomic status

* More likely to listen to health promotion messages and act upon them
* Are able to afford private health insurance and therefore wait shorter periods for treatment
* Their place of residency usually promotes health rather than making it deteriorate
* A higher socioeconomic status increases one’s chances of having good health

Occupation

* Each one carries an element of risk that can affect health
* General office work – risk of stress, exposure to radiation, repetitive strain injury
* Workers who use heavy machinery, involved in transport industry – greater risk of injury leading to disability or death
* Industrial processes – risk of developing cancers through chemical contamination and respiratory dysfunction through inhaling vapours
* Migrants, low income workers and the young – more likely to take risks at work to maintain employment

Access to and level of education

* Level of education generally determines their level of income, socioeconomic status and health
* The more time spent in education, greater potential to develop a good level of health literacy
* Young people who leave school early and remain unemployed are at a greater risk of developing poor mental health and depression, leading to self-harm behaviours
* Likely their socioeconomic status will remain low throughout their life
* Migrants face difficulty of learning new language, may not fully understand health promotion contained in health lessons and in the media
* Indigenous statistically tend to leave at an earlier age
* Growth in independent schools has the benefit of promoting the customs of particular cultures and may encourage better attendance rates

**Social attributes**

* Discrimination, racism and gender differences can impact the level of health achieved by those affected
* Mental health issues, substance abuse and self-harming behaviours are common and can lead to social exclusion

Social exclusion

* Feelings of disempowerment, unable to connect with mainstream society
* Evident in anti-social behaviour: vandalism, self-harming, suicide, substance abuse, homelessness
* Young people, disabled, elderly and various ethnic groups need to know they’re able to access health services regardless of geographic location, discrimination or socioeconomic status

Discrimination

* Women’s wages are relatively lower than males
* Delayed treatment for financial reasons
* Women’s sport receives less media attention – negative impact on participation
* Narrow stereotyping – obsessed with body image
* Increased prevalence of eating disorders
* Depending on disability, person may be financially dependent on pension, limits income and results in low living standard

**Government policies and priorities**

* The federal and state governments are responsible for prioritising health care and allocating funds to the general health areas and specific population groups
* National health priority areas receive increased levels of funding
* Indigenous health is anticipated to improve as previous policies lead to ill health (there health is 2-3 times worse than that of non-indigenous people)
* Cost of health care is always increasing, means competing priorities for government funding
* Some areas won’t receive as much funds as they require
* ‘lifetime health cover’ designed to ease burden on public health-care system by encouraging people to take out hospital insurance earlier in life (only for those who can afford it = risk)
* **What inequities are experienced by population groups in Australia?**
* **Populations experiencing health inequities** (2 areas needed for HSC of own choosing)

**Aboriginal and Torres Strait Islander**

**Homeless**

**People living with HIV/AIDS**

**Incarcerated**

**Aged**

**Culturally and linguistically diverse backgrounds**

**Unemployed**

**Geographically remote populations**

**People with disabilities**

* **How may the gap in health status of populations be bridged?**
* **Funding to improve health**

As costs of health care have increased, so had the responsibility of the government to provide cost effective management of the limited resources in health. Limited funding must be distributed in a way that responds to the needs of many groups in the population.

**Funding for health**

Almost all of the Commonwealth Government funding for the provision of health services is made up from general revenue such as taxation. The 1.5% Medicare levy covers 20% of the total Commonwealth government health expenditure

The main kinds of Commonwealth health funding mechanisms are:

* Health-care agreement grants
* Medical benefits that provide rebates
* Pharmaceutical benefits scheme
* Health program grants

**Funding for specific populations**

The Australian government Department of Health and Ageing announces in its budgets the funding that will be directed to specific health areas and populations over either the year or over a 5 year period. State and territory governments allocate funds and administer specific programs. Cooperative action and the sharing of initiatives for the benefit of all Australians are features of the Council of Australian government (COAG).

**Limited resources**

Limited resources are reflected in long waiting lists. Government initiative ‘lifetime health cover’ aims to encourage a larger proportion of the population back into private health insurance so that individuals will contribute more to their own health care.

Rising cost of wages and modern technology has increased level of accountability by governments and the health-care system. Distribution of resources occurs so areas of greatest need are established. This has led to the closure of some hospitals and the opening of others in higher demand areas. This may be good for majority but what about the minority?

* **Actions that improve health**

**Enabling (using knowledge and skills for change)**

Enabling refers to an individuals’ control over the cultural, social and economic factors that affect their health and health potential. Supportive environments, access to information, strong life skills, opportunities to make health choices promote enabling

Self-empowerment encourages use of knowledge and skills to promote lifestyle changes – long term and beneficial. Emphasis on developing partnerships with health workers and other health activists who can provide access to health information, help with health skills development and lobby to reshape public health policy

**Mediating (working for consensus)**

Mediating means working to bring about consensus and reconciling the different interests of individuals, communities and sectors in a way that promotes and protects health. The decisions will reflect a greater empathy for disadvantaged groups and local needs because they take into account different social, cultural and economic conditions.

**Advocating (speaking up for specific groups, their needs and concerns)**

Advocating for health is a combination of individual and social actions designed to speak up for specific groups, gain political commitment, policy support, social acceptance and systems support for a particular health goal or program. Leads to a more coherent, community-centred and culturally appropriate health policy

* **A social justice framework for addressing health inequities**

Social justice is a value that favours the reduction or elimination of inequity, the promotion of inclusiveness of diversity, and the establishment of environments that are supportive of all people.

**Empowering individuals in disadvantaged circumstances**

* Priority is improving their level of health literacy
* Empowering individuals so they can cope with circumstances and develop problem-solving skills
* Encourage to accept responsibility for own health so they are more likely to pursue healthier lifestyles and adopt health-promoting behaviours
* Strong personal support networks essential in giving confidence to make lifestyle changes

**Empowering disadvantaged communities**

* Instil a sense of ‘connectedness’ in members by creating a network
* Individuals who in the past felt disempowered soon develop a sense of empowerment by being part of a group that makes decisions affecting their health
* Can plan and implement programs that are culturally sensitive and specific to their needs
* May involve changing aspects of their environment, finding information, reallocating resources or advocating the review of policies that make them disadvantaged
* Lobbying governments to increase awareness in wider community and help educate members in other similar communities

**Improving access to facilities and services**

* Improving infrastructure allows disadvantaged individuals to seek treatment earlier and regularly
* More indigenous primary health care workers and more purpose built facilities that cater for cultural differences will improve access to health

**Encouraging economic and cultural change**

* Government funding is essential to building supportive environments that promote better health for disadvantaged groups
* Adequate health infrastructure ensures may no longer need to live in conditions that perpetuate the cycle for ill health
* Health inequity will not be addressed unless the population considers it to be an important enough issue. This can be done through lobbying the government to change people’s attitudes
* **Characteristics of effective health promotion strategies**

**Working with the target group in program design and implementation**

Students and other groups should identify the key health issues and environmental circumstances that result in any health inequities. They may choose to conduct surveys or questionnaires of fellow students or parents to determine issues of importance. Involved in SRC to raise issues, through involvement, learn about interrelatedness of health and the natural and social environment

**Ensuring cultural relevance and appropriateness**

* Languages spoken by students, the sports played, subjects it emphasises, its rules, and its important events and celebrations
* Minority ethnic groups may take up large proportion of schools population
* Can adopt policies and procedures that complement what is taking place in peoples’ homes
* Schools also address specific health problems

**Focusing on skills, education and prevention**

In order to focus on these things, the curriculum can be developed across all key learning areas to promote health

E.g. PDHPE in class can be supported by the use of relevant news articles and stories in English classes, thereby consolidating students’ health literacy skills. Other approaches to consider are:

* Encouraging students to develop skills in decision making, problem solving and interacting through all the key learning areas
* Giving students opportunities to practise healthy decision making
* Educating parents about the problems that young people face
* Educating students about the problems faced by other young people

**Supporting the whole population while directing extra resources to those in high risk groups**

A school with an effective health-promoting strategy may need to seek or allocate additional resources to target groups within the school who are particularly at risk of poor health e.g. those most likely to have inadequate nutrition at home, or those suffering from eating disorders such as anorexia. School would still need to ensure that attention is paid to overall health-promoting strategy that affects the rest of the students. Support of whole school required to achieve this balance.

**Intersectoral collaboration**

Collaboration between the health sectors, the Dep. Of Education and Training & a NGO led to the introduction of Life Education vans to some schools. Other e.g. of collaboration between sectors are:

* Healthy Canteen policy in some schools leading to negotiations with businesses that provide food to the schools
* Working with family and community groups to provide programs such as reading support
* Schools need to consider similar ways of involving various sectors, for e.g.
	+ - Finding businesses to sponsor events
		- Getting then school involved in Jump Rope for Heart
		- Fundraising in the community for the purchase of equipment and the building of facilities

**Summary of topic**

* Keys to social justice principles are valuing diversity, achieving equity and creating supportive environments
* Disadvantaged groups in the population may be exposed to multiple social risk factors, which contribute to health inequity
* Health inequities arise because of differences in daily living conditions, the quality of early years of life, access to services and transport, socioeconomic factors, social attributes and government policies and priorities
* Funding alone will not solve all health inequity problems, the appropriate health infrastructure is also needed
* The Medicare levy (1.5%) covers only 20% of the total health expenditure, the balance being made up from general revenue
* The main types of health action that create sustainable improvements in the health of disadvantaged groups are enabling, mediating and advocating
* Social justice framework for addressing health inequities includes empowering individuals in disadvantaged circumstances, empowering disadvantaged communities, improving access to facilities and services and encouraging economic and cultural change
* The gap in health inequity is increasing for some populations
* The health of indigenous people is 2-3 times worse than the rest of the population
* In rural areas, levels of health decrease as remoteness increases
* Rural people are exposed to higher risk of work-related injuries
* Males make up 93% of the incarcerated population, with 25% from indigenous backgrounds
* 1 in 8 Australians is an aged person
* Australia has the largest immigration population in the world, 1 in 7 was born in non-English speaking country
* Young people are especially vulnerable to unemployment and made up 38% of unemployed population in 2006
* 20% of Australian population was affected by some type of disability in 2003

All notes summarised from **Outcomes, HSC COURSE FOURTH EDITION by Ron Ruskin, Kim Proctor and David Neeves.**