THE COST OF INACTION ON THE SOCIAL DETERMINANTS OF HEALTH: LOSS OF SOCIAL AND ECONOMIC GAINS FROM HEALTH INEQUALITIES IN AUSTRALIANS OF WORKING AGE

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Research Director of NATSEM’s Health, Disability & Ageing Research Team
NWM RMF Integrated Planning Planning Conference, Melbourne
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OUTLINE

• Context
  ● NATSEM
  ● Social Determinants of Health
  ● Social Inclusion Agenda

• Current Socio-economic Inequalities in Health
  ● Australians of working age (25-64 years)

• Cost of inaction

• Concluding remarks
NATSEM’s Health Research

focuses on the detailed analysis of microdata – information collected at the person, household or small area level - and the development and application of health and aged care simulation models

• Understanding health reform: health services utilisation, expenditure and funding
• Chronic disease and future health impacts
• Equity, access and social determinants of health (SDoH)
• Ageing, aged care and the wellbeing of older Australians
• Disability and caring
• Health and socio-economic disadvantage of Indigenous Australians and other marginalised
Genetic, biological & psychological makeup

Early life (intrauterine conditions, early childhood experiences)

Education

Living conditions/housing

Behaviour & lifestyle (diet, physical activity, smoking, alcohol consumption, illicit drug use)

Neighbourhood conditions

Physical and Social Environments

Employment & working conditions

Social inclusion

Health Care

PATHWAYS to HEALTH

NATSEM
at the University of Canberra
A SOCIAL INCLUSION AGENDA THROUGH INTEGRATED PLANNING?

- Ongoing development and progressing of a social inclusion agenda in Australia gives rise to an opportunity to address the SDoH

- Vision - all Australians feel valued and have the opportunity to participate fully in the life of our society. All Australians will have the resources, opportunities and capability to:
  - learn by participating in education and training;
  - work by participating in employment, in voluntary work and in family and caring;
  - engage by connecting with people and using their local community’s resources; and
  - have a voice so that they can influence decisions that affect them.
CHA-NATSEM Second Report on Health Inequalities

THE COST OF INACTION ON THE SOCIAL DETERMINANTS OF HEALTH

MAY 2012
### SOCIO-ECONOMIC LENS to HEALTH INEQUALITIES

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>Annual disposable household income in last financial year, equivalised to household size and structure, and reported by quintile.</td>
</tr>
<tr>
<td>Education</td>
<td>Highest educational qualification categorised as: year 11 and below, year 12 or vocational qualification, and tertiary education.</td>
</tr>
<tr>
<td>Labour market (employment)</td>
<td>Jobless households: a household with all adult members either unemployed or not in the labour force.</td>
</tr>
<tr>
<td>Housing</td>
<td>Tenure type of the household – owner, purchaser, private renter, public renter or rent other/free.</td>
</tr>
<tr>
<td>Social inclusion (connectedness)</td>
<td>Based on the frequency of gathering with friends/relatives, perceived availability of someone to confide in at difficult times, and feeling of loneliness. Classified as low, moderate or high.</td>
</tr>
</tbody>
</table>
HEALTH INEQUALITIES IN AUSTRALIANS OF WORKING AGE

Per cent of persons reporting good health, by sex, age and income quintile (2008)

Source: CHA-NATSEM Report on Health Inequalities
HEALTH INEQUALITIES IN AUSTRALIANS OF WORKING AGE

Per cent of persons reporting good health, by sex, age and joblessness (2008)

Source: CHA-NATSEM Report on Health Inequalities
HEALTH INEQUALITIES IN AUSTRALIANS OF WORKING AGE

Per cent of persons reporting good health, by sex, age and housing tenure (2008)

Source: CHA-NATSEM Report on Health
HEALTH INEQUALITIES IN AUSTRALIANS OF WORKING AGE

• Similar patterns for long-term health conditions

• Inequalities in health risk factors
  ● Smoking
  ● Obesity
  ● Physical activity
  ● At risk alcohol consumption

*Health inequalities will persist because inequalities will persist in the socio-economic determinants of health.*
THE COST OF [GOVERNMENT] INACTION ON THE SOCIAL DETERMINANTS OF HEALTH

LOSS OF SOCIAL AND ECONOMIC GAINS FROM HEALTH INEQUALITIES IN AUSTRALIANS OF WORKING AGE
APPROACH

1. **Inequality in health** between socio-economic groups
   - Difference in proportions in good (self-assessed) health
   - Difference in proportions with longterm health conditions (LTCs)

2. **Inequality in social and economic outcomes**
   between people in good versus poor health (and without and with LTCs) in same socio-economic group
Close socio-economic gaps in health

⇒ more people in good health or free from LTCs

⇒ improved social and economic outcomes

Govt & community inaction ⇒ lost benefits
INEQUALITY IN SELF-ASSESSED HEALTH STATUS
increase in numbers of males aged 45-64 years in lowest income quintile reporting
good health through closing the health gap between most and least disadvantaged
Australians of working age

56.6% in
good health

86.5% in
good health

= 137,000 additional
men in good health
What potential social and economic gains might accrue if socio-economically disadvantaged groups have the same health profile of more socio-economically advantaged Australians?

<table>
<thead>
<tr>
<th></th>
<th>Most Disadvantaged</th>
<th>vs</th>
<th>Least Disadvantaged</th>
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</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td>bottom quintile</td>
<td>vs</td>
<td>top quintile</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>≤year 11 schooling</td>
<td>vs</td>
<td>tertiary qualification</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td>public renter</td>
<td>vs</td>
<td>homeowner</td>
</tr>
<tr>
<td><strong>Social connectedness</strong></td>
<td>low</td>
<td>vs</td>
<td>high</td>
</tr>
</tbody>
</table>
### OUTCOME MEASURES

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Health</td>
<td>Increase in numbers in good health or free from long-term health conditions</td>
</tr>
<tr>
<td>Satisfaction with Life</td>
<td>Increase in numbers satisfied with their life</td>
</tr>
<tr>
<td>Economic benefits</td>
<td>Increase in numbers employed</td>
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<tr>
<td></td>
<td>Increase in earnings</td>
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<td></td>
<td>Reduction in Government benefits &amp; transfers</td>
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<tr>
<td>Savings to Health System</td>
<td>Reduction in the use and cost of hospitals, doctor and medical related services, and prescribed medicines</td>
</tr>
</tbody>
</table>
Additional numbers of most disadvantaged Australians in good health or free from LTCs from closing the health gap between most and least disadvantaged Australians of working age.
Percentage of disadvantaged persons of working age satisfied with their lives by health status

![Bar chart showing the percentage of satisfied individuals across different age groups, income quintiles, and health statuses.](chart.png)
Increase in numbers employed through closing the health gap between most and least disadvantaged Australians of working age
Increase in annual earnings from wages and salaries closing the health gap between most and least disadvantaged Australians of working age.
Summary

- Some **400,000** additional socio-economically disadvantaged Australians of working age would have good health status and nearly **500,000** would be free from LTCs
- As many as **120,000** additional socio-economically disadvantaged Australians of working age would be satisfied with their lives
- Over **170,000** additional people in full or part-time employment
- Up to **$8.0bn** in extra earnings from wages and salaries
- **$3-4bn** in savings per year in Govt expenditure on pensions and allowances
Savings to the Health System

- Over 60,000 individuals may not have been admitted to hospital and over half a million hospital separations may not have occurred – saving around $2.3bn

- Reduction in use of Medicare by over 5.5m services saving Govt around $273m p.a.

- Over 5.3m PBS scripts would not have been required by concessional patients yielding $184.7m in savings to Govt p.a.
CONCLUSIONS

• Social determinants of health span the life course

• Reducing health inequalities is a matter of social fairness and social justice
  • does a person have enough money to live healthily, to live in a decent house or apartment, with a good level of knowledge and understanding, and support from family and friends, to eat and drink healthily and take sufficient exercise and not smoke?

• Health inequalities will persist unless inequalities in the social determinants of health are overcome
CONCLUSIONS Cont.

• Taking action to reduce inequalities in health does not require a separate health agenda but action across the whole of government through integrated planning

⇒ Health in All Policies
HiAP – Integrated Planning as a Solution to ‘Wicked’ Problems?

- requires collaboration
- not closed “organisational minds”
- look broadly at the issues
- use all of the available resources
- involve agencies in initial policy development
- have a lead agency as an enabler of whole of government initiatives

What are the costs of inaction?