

HEALTH AND WELLBEING



CONTEXT

Poverty and poor health and wellbeing are inextricably linked. Research from around the world has consistently shown that the poor are more likely to suffer ill health than well off members of society^{1, 2}. Health inequities remain a persistent and enduring feature of Australian society. Recent data from the World Health Organisation also suggests that in Australia, behaviours that pose a risk to health such as smoking and obesity are increasing, particularly among lower socio-economic groups³. Despite a period of sustained economic growth, health inequities on a range of indicators have also increased in South Australia – for example the number of babies born with low birth weight⁴.

SACOSS seeks the eradication of health status inequities across all population groups and the establishment of a primary health care focus for wellbeing in the state. This chapter outlines some of the key challenges facing health care in South Australia, and sets out a series of strategies that can work towards the eradication of poverty and health inequities in the state.

SACOSS adopts the framework of the ‘social determinants of health’ as its starting point for tackling health inequities. To understand this approach it is worth making

the distinction between health inequality and health inequity. Health inequalities refer to the differences in health status of individuals and groups across different socio-economic and ethnic or racial groups⁵. The difference between health inequality and inequity is outlined here:

Not all health inequalities are unjust or inequitable. If good health were simply unattainable, this would be unfortunate but not unjust. Where inequalities in health are avoidable, yet are not avoided, they are inequitable⁶.

SACOSS seeks to eradicate health inequity in South Australia. To understand why health inequity occurs the broader social and economic conditions need to be understood. The social determinants of health approach suggests that the

social, political, environmental, and economic conditions of people’s lives affect their health⁷. Some of the most significant determinants include income, socio-economic position, social support, education, employment, social and physical environments, gender, and access to services. This approach to tackling health inequity is supported by research from the Healthy Cities Program that argues⁸;

The home, the school, the town, the workplace, the city are the places or ‘settings’ that affect or ‘determine’ our health. The health status is often determined more by the conditions in these settings than by the provision of health care facilities

In sum, there are a wide range of issues and conditions which are beyond the control of an individual, but can have a significant impact on their health.

Tackling health inequities and particularly improving health outcomes for the poorest groups in South Australia requires a holistic approach. This means linking different agendas and making connections that have not historically taken place. Some of the key determinants are outlined in Figure 34.

The Social Determinants of Health and Wellbeing

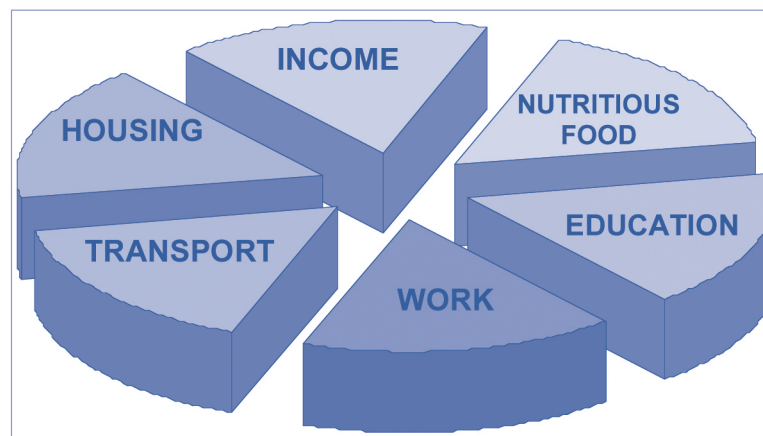


Figure 34

RESEARCH

There is a persistent and entrenched 'social gradient' where people further down the social ladder 'run at least twice the risk of serious illness and premature death as those near the top'⁹. Research from the 1990s suggests that over a third of male deaths in Adelaide could be directly linked to disadvantage¹⁰.

Some groups of people living in South Australia suffer disproportionately from lower health outcomes than other groups. As has been well catalogued, the starkest and most endemic health gaps are those between Aboriginal and Torres Strait Islander people and the wider population. Aboriginal and Torres Strait Islander people do not live as long, and life expectancy is about 17 years less than for other South Australians¹¹. Aboriginal and Torres Strait Islander people are more likely to have diabetes and a range of communicable diseases, self-harm, have mental illness and experience higher levels of interpersonal violence. The relatively poorer health outcomes experienced by Aboriginal and Torres Strait Islander people can be directly linked to a range of other social determinants and factors that include poorer educational outcomes, poor housing conditions, and racism and discrimination¹².

Recent research has also shown that Aboriginal and Torres Strait Islander people in Australia have scandalously poorer health even when compared with other

indigenous groups from other wealthy countries¹³. For example, Australia has the largest gap in life expectancy for indigenous people compared with the non-indigenous population.

Approximately 13% of Aboriginal and Torres Strait Islander babies born in Australia are of low birth weight, which is more than double the rate compared with indigenous babies in Canada and the US, and more than 60% higher than the same group in New Zealand¹⁴ (Figure 35).

A snapshot of a number of main health indicators in South Australia confirms these overall health inequities (Figure 36).

In general, the data confirms the huge disparities in health status inequities between Aboriginal and Torres Strait Islander people and the wider population. On some issues, such as rates of premature mortality, South Australia lags behind the national average. Critically, in all the indicators, the 'social gradient' is a pervasive feature of the health of

South Australians. The report 'Inequality in South Australia'¹⁶ presents a clear and unambiguous picture where people from low income households suffer poorer health outcomes.

The human and social costs of these patterns of disadvantage are well documented. However, the economic costs are less well researched. There is evidence that increasing life expectancy at birth by 10% will increase the economic growth of a nation by 0.35% a year¹⁷. Good health, therefore, is an essential component of an economically prosperous society.

SACOSS believes that concerted action has to be taken to tackle health inequalities towards the overall aim of eradicating

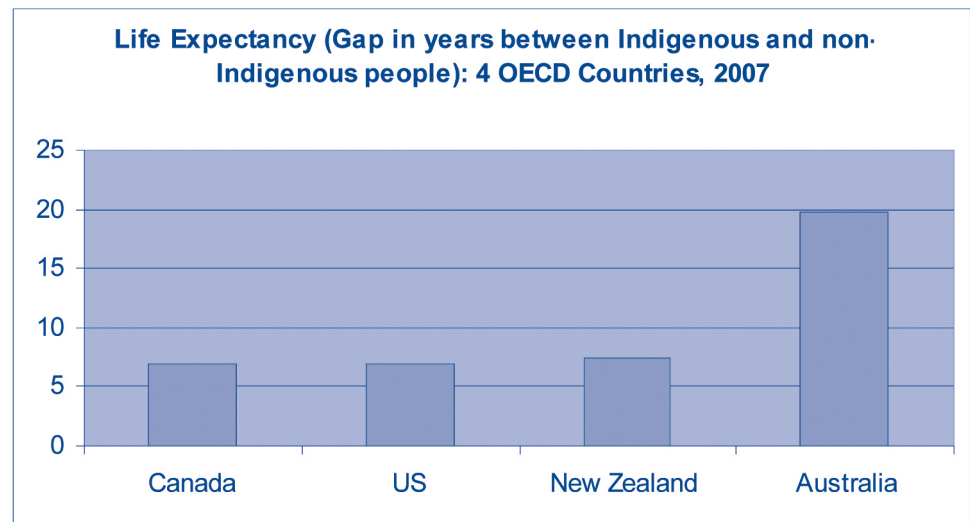


Figure 35

Data taken from Oxfam Report 'Close the Gap' (2007, p.6)

poverty in South Australia. As we outlined in the first version of the *Blueprint*, action should be taken in two broad headings:

- **Focus on prevention and early intervention**
- **Access and equity of outcomes**

Under each of these headings, we highlight some of the key research, make links with relevant government (and other) strategies; and highlight targets and strategies that, if adopted, can make a meaningful difference to eradicating poverty in South Australia.

FOCUS ON PREVENTION AND EARLY INTERVENTION CONTEXT

SACOSS believes that the focus on health services provision has to move from tertiary to primary health care. The case for shifting health care from tertiary care to primary health care is supported by a wide range of international research^{18 19}. Research from the World Health Organisation²⁰ concludes that shifting health services to primary health care has the following benefits:

International studies show that the strength of a country's primary care system is associated with improved

Figure 36: Key Health Indicators in South Australia				
Indicator	SA	Differences between different populations		
		South Australia compared with Australia	Indigenous compared with non-indigenous in SA	Lowest compared with highest socio-econ status in SA
Life expectancy (yrs)				
At birth – males	76.4	+0.2yrs	-22.0 yrs	-3.6yrs
At birth – females	82.1	+0.3yrs	-19.6 yrs	-1.9yrs
At 65 years	17.3	0.0yrs	-5.9 yrs	-0.8yrs
Self-rated health (% rating)				
Health as fair or poor	18.2	+2.0%	-	+73.6%
Infant mortality rate	4.3	-24.6%	+46.2%	+62.9%
Premature mortality (rate)	168	-2.5%	+4.1 times	+2.8 times
Substantiated cases of child abuse and neglect rate	747	-	-	+12.8 times
Educational participation (%)	80.1	+4.7%	-	-31.8%
Unemployment (%)	6.8	+8.3%	-	+5.6 times
Index of relative Socio-economic disadvantage	995	-5	-	-39.4%

Source: Glover & Hetzel (2005) 'Health' chapter in South Australia Trends and Issues, p.233. DDF, Adelaide ¹⁵

population health outcomes for all-cause mortality, all-cause premature mortality, and cause-specific premature mortality from major respiratory and cardio-vascular diseases...

...Furthermore, increased availability of primary health care is associated with higher patient satisfaction and reduced aggregate health care spending.

Studies from developed countries demonstrate that an orientation towards a specialist-based system enforces inequity in access. Health systems in low income countries with a strong primary care orientation tend to be more pro-poor, equitable and accessible.

This research overwhelmingly confirms the benefits for all groups, particularly those from low income and disadvantaged groups, when a shift in focus to primary health care occurs. SACOSS strongly advocates for a primary health care approach to tackling health inequities and eradicating poverty in South Australia. To understand what we mean by primary health care it is important to demarcate this from the narrower primary care approach. A useful distinction between primary health care and primary care is outlined here:

PRIMARY HEALTH CARE

Primary health care seeks to extend the first level of the health system from acute hospital setting care to the promotion and development of good health. It seeks to

protect and promote the health of defined communities and to address individual and population health problems at an early stage. Primary health care services involve continuity of care, health promotion and education, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology²¹.

PRIMARY CARE

Primary care is more clinically focussed and, and can be considered a sub-component of the broader primary health care system. Primary care is considered health care provided by a medical professional at the client's first point of entry into the health system. Primary care is practised widely in nursing and allied health, but predominately in general practice²².

SACOSS strongly advocates for a broader community-based primary health care system. In our view, individuals and communities should be empowered and closely involved in how health care is developed and delivered, and how their health and wellbeing is shaped.

RESEARCH

Research confirms that people from lower socio-economic groups disproportionately use primary care services more than higher socio-economic groups in Australia. For example, the poorest South Australians

disproportionately consult GPs much more frequently than those from higher socio-economic groups²³.

On a wide range of measures and indicators the *Social Health Atlas of South Australia*²⁴ confirms this overall pattern. Figure 37 on the facing page compares the use of a range of different health-related services in three areas in South Australia: Port Adelaide (one of the poorest Statistical Local Areas), Burnside (one of the wealthiest) and Ceduna (covering a large rural area):

The table confirms the overall pattern that people in poorer areas tend to proportionately access health services much more than their wealthier counterparts. On the whole, the poorest people in South Australia are likely to be the unhealthiest. People in the poorest areas are:

- More likely to contact a GP
- Less likely to have private health cover
- More likely to attend Accident and Emergency
- More likely to access mental health services.

The *Social Health Atlas* also confirms these inequalities between metropolitan Adelaide and rural/regional South Australia on a range of indicators. This presents an overwhelming case that to meet the needs of the poorest – and unhealthiest – in South Australia, the focus has to shift to the provision of primary health care services.

Figure 37

Indicator	Port Adelaide (Enfield-Port)	Burnside – NE	Ceduna
Use of community health services one-to-one 2001-02 (Standardised Client Ratio – (SCR))	160 or more	40 or less	-
Use of community mental health services one-to-one 1999-2000 (SCR)	140 or more	60 or less	160 or more
Use of Child and Adolescent Mental Health Services one-to-one 2001-03 (SCR)	130 or more	70 or less	70 or less
Use of Meals on Wheels	120 or more	80-89	-
General Medical Practitioner (GMP) services to males 2002-03	115 or more	85-94	94 or less
GMP services to females (2002-03)	110 or more	90 or less	-
A & E attendances 2003-04	130 or more	70 or less	-
Outpatient Dept. Attendances 2003-04	120 or more	80 or less	-
Private Health Insurance (Per cent covered by Private health Insurance)	38% or less	68% or more	35% or less
Admissions to public acute hospitals 03-04	130 or more	70 or less	130 or more
Hospital booking lists – people waiting more than 6 months for elective (non-urgent) surgery June 2004 (Std ratio)	130 or more	70 or less	-
<p><i>Explanatory note: Measurements are for the Standardised Client Ratio - This index shows the number of clients in the SLA compared with the number expected. For entry 1 this means that the ratio in Port Adelaide is 160 clients and above for the use of community one-to-one services whereas the ratio in Burnside is less than 40 clients for the use of a similar service.</i></p>			

THE CASE FOR EARLY INTERVENTION

There is strong and powerful evidence that effective interventions in early childhood will reduce health and social inequalities^{25 26 27}. Adelaide ‘Thinker in Residence’ Dr Fraser Mustard’s research into early childhood development makes a systematic case for investing in young people²⁸. Mustard’s research shows that there is a positive correlation between high levels of literacy at a young age and higher levels of mortality rates. Mustard estimates that **in South Australia, 5000 children start school each year with problems that could have been avoided by better care in their early years**²⁹.

This is supported by research by Nobel Laureate James Heckman. Heckman’s analysis shows that investment in early childhood has clear economic as well as health benefits. He concluded from the study of human development in the US that the return for every dollar invested in preschool is much greater for the individual and society than the investment in school based programs. The return on investments in education is about three to one, in contrast to at least eight to one for early childhood development programs³⁰. By investing in early interventions, especially support for women living in the most disadvantaged conditions, health inequalities can be reduced in later life. Recent research has found that girls weighing less than 2.5kg (5.5lbs) at birth

are significantly more likely to be depressed as teenagers than those with a normal birth weight. On average, 23.5% of teenage girls with a low birth weight suffered depression each year, compared with 3.4% of those born at a normal weight³¹. Likewise World Health Organisation data shows a strong correlation between low birthweight in men, and increased occurrences of diabetes in later life³². Healthy babies make healthy adults.

On a range of health indicators, the case for early intervention in early childhood is overwhelming, particularly for children and young people from low income households.

BLUEPRINT TARGETS: PREVENTION AND EARLY INTERVENTION

In the first iteration of the *Blueprint*, SACOSS outlined a series of targets which if achieved within 10 years (2005 – 2015) would make a meaningful contribution to ending poverty in South Australia. Overall, these targets are designed to achieve the overall outcome of reducing health inequalities across the state.

In revising the *Blueprint*, we have also developed a set of measurement indicators for tracking the progress in meeting these anti-poverty targets. The measurement indicators are outlined in Chapter 7 — Measurement Indicators.

Blueprint Targets: Prevention and Early Intervention

- 15 Move the focus of health services provision from tertiary to primary health care.
- 16 Establish integrated primary health care networks, addressing dental, physical, mental and social health and wellbeing and encompassing prevention and early intervention.
- 17 Ensure access to the infrastructure required to enable all members of the community, throughout the state, to live safely and healthily.
- 18 Ensure that all children and young people have access to health education and awareness in the school curricula.

LINKS TO GOVERNMENT STRATEGIES

The SACOSS belief in the need to shift state health services from tertiary to primary health care is supported by the State government’s own findings. The Generational Health Review (GHR)³³ was a landmark independent review of the state’s health services. The GHR presents data on a range of pressures that face the South Australian health care system, such as the significant increase in the ageing population. The GHR portrays a fragmented, complex health system in South Australia

‘that limits system effectiveness’ (GHR, p.63). The report found that primary health care funding was short-term and, ‘not seen as typically core business, and in many areas is reliant on a surplus budget’ (GHR, p.65). Overall, the report portrays a health service that is not meeting the health needs of South Australians, particularly Aboriginal and Torres Strait Islander people. Crucially, the GHR makes the case for developing a primary health care focused system in South Australia.

These issues are widely recognised across the State government, and there are many strategies, activities and further research being undertaken to facilitate this change in priority. The government response ‘First steps forward’³⁴ outlines 52 areas of work in how they are pursuing the health reform agenda, and gives consideration to two thirds of the GHR recommendations. Some of the government’s major projects and strategies include³⁵:

- Three Demonstration Primary Health Care Networks in South West and North/North East Adelaide
- Planning for the ‘GP Plus’ Centres commenced in 2005
- Mental Health Care Improvement Initiative

- ‘Stepping Up: A Social Inclusion Action Plan for Mental Health Reform’

It is not the aim here to outline all government activity, or indeed evaluate it in what is a fast-changing policy environment. SACOSS acknowledges the array of activities in place, and will commend the successes where demonstrable improved health outcomes are achieved, and the health inequalities in the state are significantly reduced.

The main headline targets for health and wellbeing issues are now prioritised through *South Australia’s Strategic Plan (SASP)*, which was revised in early 2007. The

second main objective in *SASP* is to ‘improve wellbeing’. This chapter of *SASP* contains a number of targets which support, to varying degrees, the SACOSS *Blueprint* agenda for a renewed focus on primary health care services as a step towards the overall eradication of poverty in South Australia.

Some of the key *SASP* health-related targets are:

- *T2.1 – T2.3 Preventive Health*
Three targets linked to preventable diseases. Targets based around smoking, healthy weight and sport and recreation
- *T2.4 – T2.6 Healthy Life Expectancy*
Three targets linked to life expectancy for all South Australians, Aboriginal South Australians and a new target for chronic

COMMUNITY CASE STUDY — OUTREACH CLEAN NEEDLE PROGRAM

This project is a collaboration of government and community sector agencies, and offers clean needle programs, equipment and education to target groups. The outreach clean needle program (CNP) targets marginalised injecting drug users, namely the homeless, Aboriginal and Torres Strait Islander people/or sex workers.

The main initiatives include:

- ‘Nu hit Outreach’ – run by Nunkuwarrin Yunti – providing outreach CNP to homeless injecting users
- SA Voice for Intravenous Education – Youth Peer Co-ordinator, with a peer education program at Second Story Youth Service
- SA Sex Industry Network - Sex Worker Peer Educators – targeting street-based sex workers providing CNP services, safe sex equipment and education.

Further Information: Drug and Alcohol Services SA www.dassa.sa.gov.au

diseases

- *T2.7 Psychological Wellbeing*
Target linked to lowering levels of mental health and ‘psychological distress’.
- *T6.3 & T6.4 Early Childhood*
Two targets related to reducing the % of babies born with low birth-weight, and improving performance on the ‘Australian Early Development Index’

While there are other explicitly ‘health’ related targets (T2.8 – T2.12) these are the ones which accord most directly with the focus on primary health and early intervention.

SACOSS has identified the above *SASP* targets as playing a crucial role in setting Government priorities and resource allocation to create a genuine primary health care system in South Australia. Critically, the underpinning strategies will be the key to meeting these *SASP* targets. Given the overall importance of these *SASP* targets to the *Blueprint* agenda, SACOSS will adopt a ‘watching brief’ over these targets and will be closely scrutinising the progress made in meeting them. However, we remain concerned that the ‘headline’ *SASP* targets are not sufficiently calibrated and differentiated to specifically address the needs of low income and disadvantaged South Australians.

ACCESS AND EQUITY OF OUTCOME

CONTEXT

The poorest and most disadvantaged groups in South Australia are significantly more likely to suffer ill-health than more affluent socio-economic groups. The social and economic conditions of a person and their wider communities can shape and determine their likely health and wellbeing. Poorer and more disadvantaged groups are much more likely to face barriers in achieving better health, and accessing health and related support services. This section focuses on a range of key issues of access and equity facing disadvantaged South Australians.

This section also strongly advocates that stronger and ‘deeper’ public empowerment and involvement (particularly by disadvantaged groups) should be a fundamental principle that underpins how health services are designed and delivered.

There is clear and stark evidence that ‘empowerment’ is an important part of public health. Where people, particularly those from socially excluded groups, feel empowered and are more involved in how they use and engage with health services they are more likely to achieve better health outcomes³⁶. Simply put, the more empowered people are the more healthy they are likely to be. There are also likely

to be other benefits. For example, World Health Organisation evidence suggests that youth empowerment programs have not only produced better health outcomes, but also positive changes such as improved school performance and higher self esteem.

RESEARCH

Patient involvement and empowerment is an essential part of overall ‘health literacy’. Studies have shown that in the self-treatment of diabetes, empowerment strategies have led to improvements in self-management and treatment satisfaction³⁷. Family-centred empowerment strategies have also led to improvements in the area of mental health. Effective strategies have seen increased care giver efficacy, coping skills and “access and effective use of health services”³⁸.

LACK OF ACCESS: INFORMATION

Ensuring good access to information and health services is a fundamental necessity for removing health inequalities. In a recent report, Australian participants from low income groups explicitly highlighted the issue of access to information as an important factor for decent health³⁹.

Increasingly, the internet is becoming one of the most powerful mediums for connecting communities. As the growth of the internet continues, so the available information about health and wellbeing

can be made more accessible to all parts of the community. In South Australia, there is marked inequality of use of the internet, and this includes factors such as availability, reliability and fundamentally, cost of access.

Data from the *Social Health Atlas of South Australia* confirms the overall patterns of a 'social gradient' on the issue of those who have access to the internet at home (see Figure 38). It is striking that low income families, jobless families, unemployed people, those in rural areas, and those living in public housing all reported lack of access to the internet as an issue. The

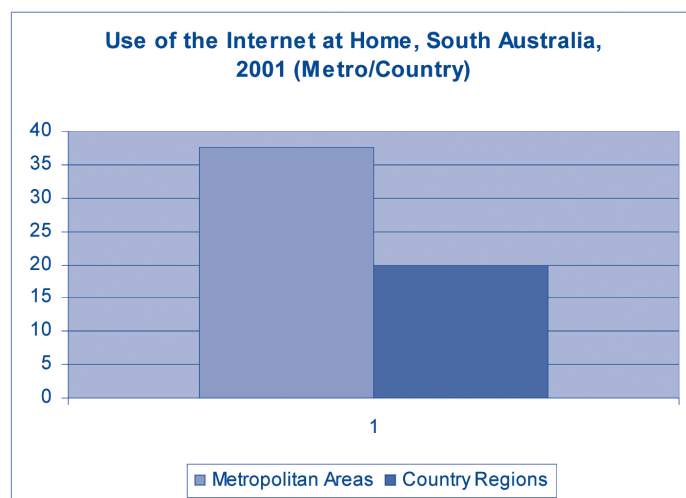


Figure 38

% of People who reported in South Australia that stated they used the internet at home (or combined with work or elsewhere) in the past week

Source: ABS Census 2001. Taken from *Social Health Atlas of Australia 3rd Edition*, p.106

opportunities that people do or do not have to access new technologies can be an indicator of their health status.

Access to information and services is fundamentally linked to overall health 'literacy'. Adelaide 'Thinker in Residence' and health consultant Ilona Kickbusch⁴⁰ argues that the notion of 'health literacy' is integral to improving health outcomes. Kickbusch argues that "Just as low literacy is linked to low health status, low health literacy contributes to economic disadvantage and may prevent individuals from fully engaging with society and achieving their life goals"⁴¹. Health literacy requires more than just providing good and reliable information. In this sense, it is essential to see overcoming the barriers in access to the relevant health information as part of a dynamic process. Research suggests that people with low health literacy are more likely to be hospitalised and are also less likely to use preventative services⁴².

LACK OF ACCESS: TRANSPORT

There are a wide range of economic, social, psychological, cultural and physical barriers that stop many groups of people living a full and prosperous healthy life. One of the main barriers for people accessing health services is the lack of transport, particularly for people in rural and remote areas of South Australia. At the 2001 census, in

metropolitan Adelaide 10.9% of dwellings had no motor vehicle whereas 7.4% of country-based dwellings had no motor vehicle. The *Social Health Atlas of South Australia* confirms that the patterns of low car ownership across the state are also clearly linked to people living in public rental housing, low income families, jobless families and the Aboriginal and Torres Strait Islander population⁴³.

While car ownership is, not surprisingly, higher in the remote and rural parts of the state it is clear that a small but significant minority of people have much more limited access to transport, and as a result access to appropriate health services (particularly specialist treatment which tends to be based in Adelaide). The *Social Atlas* also confirms that in the 'Northern and Far Western' region of the state the number of dwellings with no motor vehicle is 13.1%, significantly higher than the state average.

Information about the health impacts on other aspects of transport in Australia, particularly public transport, is very limited. During the 2006 community consultation on *South Australia's Strategic Plan (SASP)*, it was clear from the regional forums that increased investment in infrastructure and regular and reliable public transport were key issues. However, this is a crude proxy or guide for establishing how the transport needs of the poorest (and unhealthiest) groups – particularly in remote and rural areas – in South Australia will be identified

and met. At a state level it is unclear to what degree health appointments are cancelled or not made due to lack of transport issues.

In the UK, there is more evidence about the issues surrounding lack of access to transport issues, and their impact on health status^{44 45}. In the UK, it was reported that over a 12 month period, 1.4 million people miss, turn down or choose not to seek medical help because of transport problems. The UK Independent Inquiry found that:

“...Lack of access to transport is experienced disproportionately by women, children, disabled people, people from minority ethnic groups, older people and people with low socioeconomic status, especially those living in remote rural areas...

Older and disabled people are more likely to have low incomes and to be reliant on public transport. The price of public transport is thus a critical issue in their mobility”.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

As outlined above, Aboriginal and Torres Strait Islander South Australians are much more likely to suffer poorer health than the wider population. The issues of access to good health are therefore much more pronounced for this population group. Research has “long identified social inequality, racism, and oppression as the key issues in Aboriginal health and wellbeing”⁴⁶.

Along with the common range of healthy indicators (such as chronic

disease and prevalence of mental health) which show the large health inequalities experienced by Aboriginal and Torres Strait Islander people, there are also other environmental risk factors that reinforce the overall patterns of lack of access for these communities:

“Many Aboriginal people in remote communities do not have access to the same range and cost options for healthy food as non-Aboriginal South Australians. The ability to prepare and store fresh food is also limited by the lack of adequate facilities and infrastructure, such as kitchens, storage facilities, and a reliable source of electricity.

COMMUNITY CASE STUDY — 'COMMUNITY FOODIES' PROJECT

This project was set up in 2001 by Noarlunga Health Services (NHS) in response to community members wanting to learn more about nutrition. A number of programs such as 'cheap Easy Meals' were developed at NHS and following an evaluation extended as a statewide initiative.

Community Foodies is now proceeding as a statewide peer education project with a strong focus on community development. It aims to increase the access of people to nutrition and skills, by training and supporting local community members in many aspects of food and nutrition. 'Community Foodies' refers to the community members who take an interest in improving health and wellbeing and are trained to run the programs in their local community.

To date, 90 community members have been trained in the scheme.

*Further Information: Southern Primary Health – Noarlunga
www.health.sa.gov.au/pehs/branches/health-promotion/fairer-society-vol2-06.pdf*

*Thus, there is an urgent need to improve standards of environmental health, including housing and essential services, for these Aboriginal Communities*⁴⁷.

DISABILITY ISSUES

There are a wide range of significant barriers that many people who have a disability experience in everyday life. For those people with mobility-related disabilities, there are barriers in accessing and using public transport. For those who own a motor vehicle, there are additional costs in the maintenance and running, particularly for the costs associated with adapting the vehicle. Many people with disabilities also face stigmatisation and discrimination in their lives, which also impacts on their overall health.

As outlined in Chapter 2 — Income, people with disabilities are more likely to live in households that live in poverty. For example, nearly 50% of single people with a disability who live on their own are likely to live in poverty (60% of median income) than single people with no disability (17.9%)⁴⁸. Research shows that there is strong evidence of an ‘income penalty’ when disability is present in a household, and there are significant additional costs related to disability. Using a range of indicators of financial stress and hardship, research shows that 12.4% of all households with a disability suffer ‘severe hardship’

compared with 5.8% of all households with no disability⁴⁹.

The range of potential barriers faced by people with disabilities is huge, and includes the lack of appropriate access to information for people who are deaf/hearing impaired and those who are visually impaired, and appropriate support and resources for the carers of people with disabilities. The complexity of need is also reinforced by the differential needs of different population groups who have a disability, for example the needs of women with disabilities, older and young people, and ethnic minority and Aboriginal and Torres Strait Islander people.

COSTS AND AVAILABILITY

While there is a good deal of data on a range of health indicators and health inequities, more often the voices of low income Australians are absent from the overall picture. A recent report has given ‘voice’ to many of these groups and a range of concerns related to health were expressed⁵⁰. Affordable health care was seen as the main underpinning theme. Participants in the study reported that the high costs of prescriptions and medication were “a significant problem”, including the costs of rehabilitative and specialist services. The costs of private health insurance were also singled out as excluding many low income people from accessing health care. Moreover, it was apparent from the concerns of the participants that ensuring

good healthcare also could entail additional costs, such as car parking, or days taken from leave at work.

The participants in the survey also strongly agreed about the inadequacy of current arrangements to the costs of dental health treatment – which was seen as too prohibitive to be accessible.

The other major theme to arise was the range of services available, and many of the participants felt that long waiting lists were a barrier for accessing health care. Some participants also expressed concern that the criteria for accessing some services, particularly mental health services, was a significant barrier. The lack of available resources in remote and rural areas was also identified strongly by the participants.

MENTAL HEALTH AS A BARRIER

Good mental health and psychological wellbeing is an integral part of a functional society. According to the World Health Organisation there are significant mental health inequalities across different population groups. Poverty is an issue that connects many of these groups. The risk of mental ill-health is higher among those who are “poor, homeless, unemployed, those with low education, victims of violence, migrants and refugees, indigenous populations, children and adolescents, abused women, and the neglected elderly”^{51 52}. Research confirms that schizophrenia occurs most

frequently where there is poverty and disadvantage⁵³.

It is estimated that one in five people in Australia will experience a mental health problem, which equates to 250,000 South Australians⁵⁴. In Australia, a significant part of the population will experience mental ill-health, and this also impacts on other family members and carers. In 2001, an estimated 111,814 people in the Adelaide metropolitan areas reported mental and behavioural disorders; a rate of 106.7 per 1,000 people⁵⁵.

Mental health is also strongly linked to physical health, and in Australia “depression is the fourth leading cause of disease burden, with high associated costs including reduced work productivity, days of lost work, educational failure, poor family functioning, poor social functioning, a diminished sense of wellbeing and increased use of health services”⁵⁶.

LANGUAGE/CULTURE ISSUES

There are also many barriers to accessing health services and other facilities for people who are not from the dominant cultural background in South Australia, particularly for those whose first language is not English. There are a wide range of cultural and language barriers that can have an impact on their health status. South Australia has a diverse and rich population, evidenced by the

2001 census showing 20.3% of the South Australian population were born overseas. Additionally, approximately, 11.6% of the South Australian total population spoke a language other than English at home.

A recent report comparing four regions in South Australia showed that the region with the lowest health outcomes also had disproportionately less people living there who spoke English at home⁵⁷. In the Playford region 75.4% of people spoke English at home compared with 93.3% in Burnside. The health inequities between the two regions were considerable. Language and cultural differences are part of a range of factors that can determine health status. Culturally (and language) appropriate health services that are responsive to the local needs of the community are vital for ensuring good health outcomes for all parts of the community. Academic research reinforces the complex health needs, particularly for newly arrived refugee children, and that there are a range of ‘access’ issues including overcoming distrust of government services⁵⁸.

BLUEPRINT TARGETS: ACCESS AND EQUITY OF OUTCOMES

Outlined below are the key *Blueprint* Targets devised to focus action on improving access and equity of outcomes under the ‘health and wellbeing’ theme. A set of measurement indicators which can be used to track progress in meeting these targets is in Chapter 7 — Measurement Indicators.

Blueprint Targets: Access and Equity of Outcomes

- 19 Provide equity of access to all public and private health-related services for all communities.**
- 20 Eliminate health status inequalities in all areas for populations within the state, based on geographic and population groups, to a variable rate of no greater than 10%.**
- 21 Ensure access to affordable, healthy food for all communities.**
- 22 Reduce waiting lists to ensure sufficiently timely access to health services such that any wait does not compound either the medical condition or adversely impact on an individuals wellbeing or circumstance.**

LINKS TO GOVERNMENT STRATEGIES

The *Generational Health Review* highlighted a number of issues related to access to health services. There is also a wide range of government activity which is addressing some of the issues identified here. As noted above, the primary instrument for directing government activity on health and wellbeing is *South Australia's Strategic Plan (SASP)*. There are a number of key targets which directly and indirectly will work towards removing barriers to improve the health of some of the poorest and most marginal groups in South Australia.

SASP targets listed here will play a key role in improving access to health services for the most disadvantaged population groups, as well as achieving greater equity of health status outcomes and supporting the overall *Blueprint* agenda to eradicate poverty in South Australia.

- *T2.1 – T2.3 Preventive Health*
Three targets linked to preventable diseases. Targets based around smoking, healthy weight and sport and recreation
- *T2.4 – T2.6 Healthy Life Expectancy*
Three targets linked to life expectancy for all South Australians, Aboriginal South Australians and a new target for chronic diseases
- *T2.7 Psychological Wellbeing*
Target linked to lowering levels of mental health and 'psychological distress'.

- *T6.3 & T6.4 Early Childhood*
Two targets related to reducing the % of babies born with low birth-weight, and improving performance on the 'Australian Early Development Index'

While there are other explicitly 'health' related targets (T2.8 – T2.12) these are the ones that accord most directly with the focus on primary health and early intervention.

Critically, the underpinning strategies will be the key to meeting these *SASP* targets. Given the overall importance of these *SASP* targets to the *Blueprint* agenda, SACOSS will adopt a 'watching brief' over these targets and will be closely scrutinising the progress made in meeting these *SASP* targets. However, we remain concerned that the 'headline' *SASP* targets are not sufficiently calibrated and differentiated to specifically address the needs of low income and disadvantaged South Australians.

STRATEGIES

SACOSS has outlined some of the key research that makes a compelling case for significant investment in primary health care services in South Australia, which will contribute to the overall eradication of poverty in the state.

The SACOSS *Blueprint* sets out the key targets which, if met, could make a significant contribution to the eradication of poverty in South Australia. To help build on this work, SACOSS has developed a series of underpinning strategies which are pathways for meeting this challenge and if implemented, will make a valuable contribution in tackling poverty and inequality in South Australia.

The strategies on the following pages seek to suggest practical pathways for dealing with the range of issues outlined in this chapter but they are only part of a wider set of policy initiatives and social investment needed to tackle health inequity in South Australia.

HEALTH AND WELLBEING STRATEGIES

- 29 20% INCREASE IN REAL FUNDING TO PRIMARY HEALTH CARE
To fulfil the aims of the Generational Health Review, a significant boost to state health spending is required
- 30 ESTABLISH EARLY INTERVENTION PROGRAMS FOR KEY LIFE EVENTS AND VULNERABLE POPULATION GROUPS
The long term benefits of early intervention are greatest when directed at lower socio-economic communities, so this initiative is best based in child care centres in poorer communities. The strategy involves creating 20 early intervention workers, each working with two childcare centres, based in lower income areas
- 31 SOCIAL HEALTH IMPACT ASSESSMENTS (ON ALL NEW HEALTH LEGISLATION)
Improved social health in families, workplaces and communities markedly reduces the reliance on and use of health services and increases productivity. Social health policy screening to be built into all new state legislation and initiatives to ensure that needs of the most disadvantaged are built into the overall program design and monitoring.
- 32 ESTABLISH THE COMMISSION FOR CHILDREN AND YOUNG PEOPLE
Create a Commissioner for Children and Young People, along with an Aboriginal and Torres Strait Islander Co-commissioner. The Commissioner will provide strategic advice to government, and has powers to review and monitor relevant legislation and programs.
- 33 MINISTERIAL TASK FORCE - THE FIRST 8 YEARS
The first eight years of a child's life has been consistently indicated as being vitally significant for the continued health and wellbeing throughout human development. Early childhood programs that are developmentally interactive, include an element of physical activity, provide language skills and literacy skills and play based problem solving are important for positive development. This strategy seeks to create a taskforce of key ministers to drive proposals for new resources to support children in first eight years of their lives, with specific focus on Aboriginal and Torres Strait Islander children.
- 34 INCREASE THE NUMBER OF ABORIGINAL AND TORRES STRAIT ISLANDER MATERNAL AND INFANT CARE WORKERS
Research demonstrates that the mortality rate for Aboriginal infants is twice as high as non-Aboriginal infants. This disparity in infant mortality rates is alarming and is demonstrative of the inequities that exist in our health care system. This strategy aims to increase the overall number of Aboriginal and Torres Strait Islander maternal and infant care workers, and has been trialled in the Port Augusta region. This strategy should be rolled out across the state in relevant areas.
- 35 REVIEW AND RE-WRITE THE MENTAL HEALTH ACT 1993
The major impact of this strategy will be the provision of community based mental health supports and service coordination that satisfies both the government's duty of care and the inclusion of people with mental health issues within the community. This strategy further sets out the need to review the Mental Health Act 1993 (SA), to improve its effectiveness in improving outcomes for people with mental ill-health across the state.

36 HOMELESS PERSONS DENTAL CLINIC

This strategy called for the establishment of a Homeless Persons Dental Clinic, based in Adelaide. Dental care for homeless persons remains a key concern and this strategy seeks to improve the existing levels of services for this key population group.

37 EXPANSION OF GP PLUS CENTRES TO HAVE STRONGER PRIMARY HEALTH CARE FOCUS FOR DISADVANTAGED GROUPS

There is scope for the GP Plus Centres to have a stronger primary health care focus, and strategies in place to increase patient involvement and participation in shaping these services. This strategy seeks to develop the remit of the GP Plus Centres to focus on the wider community health needs, and have a less narrow 'clinical' approach. There is a need for increased investment and rollout of the GP Plus centres to enable them to have a wider remit, for example social workers and other community workers to support complex needs, particularly of low income groups. Outreach service workers are needed to tackle a range of issues affecting the most vulnerable from domestic violence interventions to financial management and advice.

38 CONTINUE BUILDING AND DELIVERY OF EARLY YEARS SUPPORT PROGRAMS

Increased investment and commitment for the early years support programs (Every Chance for Every Child). The government outputs to be linked to annual monitoring of health outcomes – particularly for low income groups – to ensure that the programs are effective.

39 SYSTEMATIC MAPPING OF HEALTH NEEDS OF CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) COMMUNITIES, ESPECIALLY NEWLY ARRIVED MIGRANTS AND REFUGEES

Recent immigrants to South Australia including refugees can feel isolated through language, customs and a lack of access to the information necessary to equitably access health care and intervention strategies. This strategy sets out annual health mapping of CALD communities, and through that mapping, appropriate and targeted health-related intervention strategies can be implemented.

40 REVIEW OF CURRENT INTERPRETING SERVICES AVAILABLE ACROSS THE STATE, AND INCREASE IN TARGETED AREAS FOR PEOPLE WHOSE FIRST LANGUAGE IS NOT ENGLISH

Review of the current provision of interpreting services in key health services. Once completed the review will lead to further targeted interpretation and support services.

41 REVIEW OF TRANSPORT ISSUES LINKED TO USE OF HEALTH SERVICES

This strategy involves a government review of the transport barriers facing disadvantaged groups when accessing both specialist and non-specialist health services. For example, there is evidence that many low income groups either cancel, do not attend or do not make appointments due to lack of reliable and affordable transport. The review will seek to evaluate the extent of these issues, and identify strategies for improving access for disadvantaged groups. This will include a review of the current Patient Assistance Transport Scheme.

42 TARGETED HEALTH PROMOTION CAMPAIGN FOR SINGLE MALES (40-55) AND SERVICE PROVIDERS

Single men in this age bracket remain significantly more likely to suffer health inequities. This campaign is focused on both on removing barriers for men in this group, and also on encouraging relevant service providers to recognise their needs and improve access, with the overall aim of reducing chronic illness, mental ill-health and suicide in this group.

44 WIDER ROLLOUT OF COMMUNITY 'FOODIES' PROGRAM

The Community Foodies program is a successful initiative in which workers who are trained in basic nutrition and community education skills work together with health workers to promote and encourage people to improve their health through education and better nutrition. This strategy aims to rollout the wider provision of the program.

45 INCREASE IN STATE FUNDING FOR SCHOOLS 'BREAKFAST CLUBS' AND PROVISION OF FREE SCHOOL MEALS IN TARGETED AREAS

State funding for healthy meals in schools targeting the most disadvantaged and poorest children across the state to ensure they receive at least one healthy meal during the school day.

46 INCREASE IN TRAVEL SUBSIDIES FOR RURAL PERSONS TO ATTEND NON-SPECIALIST MEDICAL SERVICES

Access to health care for rural people is becoming increasingly difficult with the attraction and retention of qualified medical practitioners to rural areas almost impossible. This strategy seeks to restore equity in access to health care by increasing travel subsidies for rural persons to attend non-specialist services.

Further details on any of these strategies can be obtained by contacting SACOSS.

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