Health Equity

Policy Position Statement

Key messages:	Health equity is about fairness. It is unfair and wrong that some groups face avoidable barriers to accessing decent health care or living conditions which carry extra but preventable risks.
	Health equity is a core responsibility of government, requiring a whole-of-government approach, and governments must be held to account for their performance in relation to health equity. Addressing health inequities also requires mobilising civil society and engaging people and communities - particularly socially and economically excluded populations – in decisions affecting their lives.
Key policy positions:	1. PHAA will work to promote equity in health in Australia and globally
	2. Public health activities and government policies should contribute to social health and equity.
Audience:	Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.
Responsibility:	PHAA Political Economy of Health Special Interest Group
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Policy position statement

PHAA affirms the following principles:

1. Health equity is about fairness of access to good health.[1] There are many causes of health inequalities, not all of which raise questions about fairness.

2. Health equity is about rights and wrongs.[2,3] Access to decent health care and enjoyment of the conditions for good health are universal human rights. It is unfair and wrong that some groups face avoidable access barriers or conditions of living which carry extra but preventable risks.

3. A strong political constituency demanding attention to fairness and inclusion is necessary to support the cultures, policies and practices needed to build health equity.

4. Health equity is a core responsibility of government and must be addressed through a whole-of-government approach and policy coherence across levels of government.

5. Governments must be held to account for their performance in relation to health equity through strong political and social movements which include the people who have most to gain from improved health equity.

6. Ensuring that people and communities are engaged in decisions affecting their lives, health and wellbeing is fundamental to good health. This is particularly the case for socially and economically excluded populations who are also most likely to have been politically excluded as well. The provision of accurate information and engagement of civil society to promote these objectives are integral to achieving this outcome.

PHAA notes the following evidence:

7. Unfair barriers to accessing decent health care reflect weaknesses in healthy system design, structural forces which maintain inequalities in income and wealth, and various forms of discrimination and marginalisation.[4]

8. Unfair health chances reflect inequalities in exposures due to economic or political inequalities, and heightened vulnerabilities as a consequence of discrimination or marginalisation.[5]

9. Aboriginal and Torres Strait Islander Peoples face access barriers and health risks which are the legacy of colonial dispossession, cultural genocide, assimilationism and institutionalised racism.[6-12] The continuing failure to implement effective governance and funding structures to resource and support Aboriginal and Torres Strait Islander leadership for empowerment and self-determination reflects a continuation of this legacy.

10. Other groups facing discrimination and marginalisation (including for example, asylum seekers, many LGBTQIA+ people, long term unemployed, people living with mental illness and survivors of family violence) also experience access barriers and disproportionate health risks.

11. Health inequities exist both within and between countries.[5,13,14] Avoidable and remediable health inequities persist in Australia[9,10,15,16] and are widening globally.[17,18]

12. Relative equality in access to material resources, a culture of security through solidarity, and fulfilment through contribution are major determinants of population health status.[19]

13. Health inequities can be exacerbated by the impacts of epidemics and pandemics, as has been shown through the recent COVID pandemic.[20,21]

14. Market approaches to health care and global economic integration present challenges in assuring universal access to health care and the social conditions for health for all.[22,23]

15. Promoting health equity calls for policy initiatives in all sectors and at all levels of government.[4]

16. In some circumstances preventive policies can exacerbate health inequalities;[24] policies for prevention and health care must be evaluated through a health equity lens.[25]

17. Government policy is driven and constrained by electoral sentiment, cultural currents, interest group pressures, and pressures arising from international economics and geopolitics. Driving towards health equity depends on mobilising civil society, pressing for democratic participation, institutional integrity, and a global governance regime which cultivates equity, sustainability and buen vivir[1].[26]

18. Implementing this policy would contribute towards the achievement of UN Sustainable Development Goals 3 – Good Health and Wellbeing and 10 – Reducing Inequalities.

PHAA seeks the following actions:

19. Governments at all levels, should:

- Commit explicitly to ensuring universal access to high quality, accessible, culturally competent, safe, efficient, publicly funded health care, based on the principles of comprehensive primary health care;
- Commit to addressing the excessive risk exposures and vulnerabilities which underlie inequities in health status;
- Adopt a cross-sectoral approach to policy development for health equity ensuring policy coherence across health care, economic policy, social protection, and social policy;
- Facilitate the participation of population groups experiencing health inequities in the planning, development, governance and evaluation of services including creating the social conditions for good health.

20. The Australian Government should:

- Undertake regular and comprehensive monitoring of health care access and outcomes and of health status, risks, resources, exposures and vulnerabilities; disaggregated so as to reveal inequities affecting various population groups;
- Report regularly to Parliament on health inequalities and inequities;

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[1] Buen Vivir: literally 'living well'; highlighted in Latin American social medicine as a culture of living based on the ancestral knowledge of indigenous peoples that aims to strike a balance, striving for harmony between humans and nature alike (Fatheuer, T. (2011). Buen Vivir a brief introduction to Latin America's new concepts for the good life and the rights of nature. Berlin, Heinrich Böll Foundation.)

- Ensure that taxation arrangements and transfer payments, are equitable, progressive and sufficient;
- Actively build a constituency in Australia for the full implementation of the 2030 Agenda for Sustainable Development and the commitments of the Paris Agreement on climate change;
- Develop and implement prospective health equity impact assessment protocols for significant public policies, and evaluate the outcomes of policies affecting health equity, including transparent and accountable processes for targeting and undertaking such assessments;
- Ensure that Australia's foreign policy settings, including defence, immigration, trade and investment and development assistance, promote access to decent health care globally and address inequities in health status, between and within countries;
- Promote and fund research into the determinants of health equity and build the evidence base for policies and programs to promote health equity, locally, nationally and globally.

21. Community, professional, commercial, educational, cultural and legal institutions and organisations should:

- Be aware of the influences arising in their regular practices which impact on health equity;
- Advocate for policies in their fields and sectors which would promote health equity;
- Hold governments accountable for implementing such policies;
- Support social and political movements working to create the conditions for health equity, locally, nationally and internationally.

PHAA resolves to:

22. Advocate for research into inequalities and inequities, with respect to access to decent health care and enjoyment of the social conditions for good health, in Australia and internationally.

23. Promote awareness in the health sector and beyond of inequities in access to health care and the conditions for good health, including causes and policy strategies.

24. Advocate that Australian governments at all levels adopt the actions listed above.

25. Work within the health system, in collaboration with other health bodies, to promote universal access to decent and comprehensive health care.

26. Build relationships and collaborate with organisations in and beyond health care to build the institutional and cultural conditions for health for all.

27. Work with training institutions and professional organisations to build the capacity of public health institutions in Australia to research, teach and practice for health equity.

28. Work with public health associations in neighbouring countries (Asia-Pacific) to better understand and address the causes of health inequities.

29. Work with global, regional and national organisations to advocate for international action to build health equity and realise the right to health.

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(First adopted 2001, revised 2002, 2006, 2009, 2012, 2016 and 2019)

References

1. Braveman P, Gruskin S. Defining equity in health. Journal of Epidemiology and Community Health 2003;57:254-8.

2. Office of the High Commissioner for Human Rights. CESCR General Comment No. 14: The right to the highest attainable standard of health (Art. 12) Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000. Document E/C.12/2000/4: UN; 2000.

3. World Health Organization. Making fair choices on the path to universal coverage. Final report of the WHO Consultative Group on Equity and Universal Health Coverage. Geneva: WHO; 2014.

4. Ottersen OP, Dasgupta J, Blouin C, et al. The political origins of health inequity: prospects for change. The Lancet 2014;383:630-67.

5. Commission for Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization; 2008.

6. Australian Institute of Health and Welfare. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2015. Cat. no. IHW 147. Canberra: AIHW; 2015.

7. Germov J, ed. Second opinion: An introduction of health sociology. 6th ed. Melbourne: Oxford University Press; 2018.

8. Griffiths K, Coleman C, Lee V, Madden R. How colonisation determines social justice and Indigenous health—a review of the literature. Journal of Population Research 2016;33:9-30.

9. Pulok MH, van Gool K, Hall J. Inequity in healthcare use among the indigenous population living in non-remote areas of Australia. Public Health 2020;186:35-43.

10. Yashadhana A, Pollard-Wharton N, Zwi AB, Biles B. Indigenous Australians at increased risk of COVID-19 due to existing health and socioeconomic inequities. The Lancet Regional Health – Western Pacific 2020;1.

11. Chaudhuri A, Shekar K, Coulter C. Post-operative deep sternal wound infections: making an early microbiological diagnosis. Eur J Cardiothorac Surg 2012;41:1304-8.

12. Pearson O, Schwartzkopff K, Dawson A, et al. Aboriginal community controlled health organisations address health equity through action on the social determinants of health of Aboriginal and Torres Strait Islander peoples in Australia. BMC Public Health 2020;20:1859.

13. Marmot M. Health equity in England: the Marmot review 10 years on. BMJ 2020;368:m693.

14. OECD. Health for Everyone?2019.

15. Australian Institute of Health and Welfare. Mortality inequalities in Australia 2009-2011. Bulletin 124. AIHW Cat. no. AUS 184. Canberra: AIHW; 2014.

16. Flavel J, Baum F. The influence of socio-economic conditions on the epidemiology of COVID-19 in Australia. Medical Journal of Australia 2022;216:344-5.

17. Mackenbach JP. Persistence of social inequalities in modern welfare states: Explanation of a paradox. Scandinavian Journal of Public Health 2017;45:113-20.

18. Goesling B, Firebaugh G. The Trend in International Health Inequality. Population and Development Review 2004;30:131-46.

19. Napier AD, Ancarno C, Butler B, et al. Culture and health. The Lancet 2014;384:1607-39.

20. Jensen N, Kelly AH, Avendano M. The COVID-19 pandemic underscores the need for an equity-focused global health agenda. Humanities and Social Sciences Communications 2021;8:15.

21. Paremoer L, Nandi S, Serag H, Baum F. Covid-19 pandemic and the social determinants of health. BMJ 2021;372:n129.

22. Labonté R, Stuckler D. The rise of neoliberalism: how bad economics imperils health and what to do about it. Journal of Epidemiology and Community Health 2016;70:312-8.

23. Seferidi P, Hone T, Duran AC, Bernabe-Ortiz A, Millett C. Global inequalities in the double burden of malnutrition and associations with globalisation: a multilevel analysis of Demographic and Health Surveys from 55 low-income and middle-income countries, 1992–2018. The Lancet Global Health 2022;10:e482-e90.

24. Baum F, Fisher M. Why behavioural health promotion endures despite its failure to reduce health inequities. Sociology of Health & Illness 2014;36:213-25.

25. Frohlich KL, Potvin L. Transcending the known in public health practice: the inequality paradox: the population approach and vulnerable populations. Am J Public Health 2008;98:216-21.

26. Calisto Friant M, Langmore J. The Buen Vivir: A Policy to Survive the Anthropocene? Global Policy 2015;6:64-71.