

## Health Equity Policy Position Statement

- Key messages:** Health equity is about fairness and social justice. It is unfair and wrong that some groups face avoidable barriers to accessing optimal health care or living conditions that carry preventable risks.
- Achieving health equity is a core responsibility of governments at all levels, requiring a whole-of-government approach. 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 societally and economically excluded populations – in decisions affecting their lives.
- Key policy positions:**
1. PHAA will work to promote equitable health outcomes in Australia and globally.
  2. Public health activities and government policies should contribute to health equity.
- Audience:** Federal, State and Territory Governments, policymakers and health program managers, PHAA members and civil society
- Responsibility:** PHAA Political Economy of Health Special Interest Group
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# Health Equity

## Policy Position Statement

### PHAA affirms the following principles:

1. *Health equity* means everyone has fair and equal access to the highest possible level of health<sup>1</sup> - defined as a state of complete physical, mental, and social wellbeing.<sup>2</sup> While *health inequalities* (i.e., differences in health status) can arise from many causes, *health inequities* are the result of unfair social, political, economic or environmental conditions.
2. Health equity is about social justice.<sup>3,4</sup> Access to optimal health care and enjoyment of the conditions for good health are universal human rights.<sup>3,4,5</sup> It is unfair and wrong that some groups face avoidable access barriers or conditions of living that carry preventable risks.
3. Health and social equity are not just moral goals; they are foundations for cohesive, resilient, democratically engaged and economically stable societies. Inequity fuels alienation and marginalisation, and erodes the social fabric, impacting everything from mental health to civic trust.
4. Achieving health equity is a core government responsibility. This means going beyond equal resource distribution and addressing structural barriers and avoidable inequalities to actively eliminate health disparities that affect marginalised populations. Effectively removing these barriers requires inclusive, whole-of-government responses across all levels.
5. Investment in early life and intergenerational approaches is vital to disrupt cycles of disadvantage and achieve long-term equity in health across the lifespan.
6. 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.
7. Ensuring that individuals and communities are engaged in policy decisions affecting their lives, health and wellbeing is fundamental to good health. This is particularly the case for socially, economically, and politically excluded populations. The engagement of civil society to promote these objectives is integral to achieving this outcome.
8. Disinformation and misinformation harms health and health equity by creating confusion, undermining trust in public health interventions, and limiting people's ability to make informed decisions.<sup>6</sup> Governments, media, corporations, and social institutions share responsibility for ensuring the public receives accurate, evidence-based information to protect health and promote fairness.
9. A strong political constituency advocating for fairness, justice, and inclusion is essential to shape a societal culture, policy environment, and practices to achieve health equity.
10. Implementing this policy would contribute to achieving the UN Sustainable Development Goal 3 - [Good Health and Wellbeing](#), Goal 10 - [Reducing Inequalities](#) and Goal 17 – [Partnerships for the Goals](#).

### PHAA notes the following evidence:

11. Health inequities exist both within and between countries.<sup>7,8,9</sup> Avoidable health inequities persist in Australia<sup>10,11</sup> and are widening globally.<sup>12,13</sup>

12. Discrimination and marginalisation results from economic, political, and social inequalities.<sup>7</sup>
13. Unfair barriers to accessing optimal health care reflect weaknesses in health system design, structural forces that maintain inequities in income and wealth, and other various forms of discrimination and marginalisation.<sup>14</sup>
14. Stark health inequalities are linked to social determinants of health, particularly socioeconomic status: <sup>11</sup> there is an average life expectancy gap in Australia of more than six years between those in the highest and lowest income groups.<sup>15</sup>
15. On average, the seven million Australians living in rural and remote areas experience shorter lives, higher rates of illness and injury, and poorer access to health care.<sup>16</sup>
16. Aboriginal and Torres Strait Islander Peoples face access barriers and ongoing health impacts which are the legacy of colonial dispossession, cultural genocide, assimilation and institutionalised racism.<sup>17-20</sup> Aboriginal community controlled health services are the most effective response to the health inequities resulting from this colonial context.<sup>20-22</sup> They produce greater service effectiveness and cultural responsiveness, higher levels of Aboriginal employment and enable formal structures for Aboriginal community decision-making.<sup>21-22</sup>
17. Other groups facing discrimination and marginalisation (including, for example, asylum seekers,<sup>23</sup> refugees, migrants, LGBTQIA+ people,<sup>24,25</sup> people with disability<sup>26</sup> or people with mental illness,<sup>27</sup> and victim survivors of family violence<sup>28</sup>) also face barriers to accessing health care and disproportionate health risks.
18. Early-life inequities, beginning from the prenatal period, have profound and lasting effects on health outcomes across the life course, often being transmitted across generations through structural disadvantage and intergenerational trauma.<sup>7</sup>
19. Global events that disrupt health, security, political and economic stability - such as climate change and the COVID-19 pandemic - significantly exacerbate existing health inequities.<sup>29-31</sup>
20. Neoliberal economic policies combined with global economic integration and rules in international trade agreements that favour high-income countries and transnational corporations have widened financial insecurity for many already marginalised groups.<sup>32</sup>
21. Access to safe, affordable and high-quality housing is a critical determinant of health. Unaffordability, poor quality or unsafe housing, insecure tenancy or lack of tenancy support for renters, or poor location of housing and lack of accessible services and social networks, contribute to poor health and wellbeing.<sup>7</sup> Housing policies - including privatisation, disinvestment in public housing, and regressive taxation that favours developers and investors - drive housing-related stress, exacerbate income inequality and the impacts of other social determinants of health and contribute to inequitable health outcomes.<sup>7</sup>
22. Market-based approaches to health care and social services that entrench a two-tier system reliant on privatised services are detrimental to ensuring universal access to health care and the social conditions for health for all.<sup>33</sup>
23. When health policies fail to address structural barriers affecting disadvantaged groups, they may exacerbate health inequities.<sup>34</sup> Preventive and other health care policies must be evaluated through a health equity lens.<sup>35</sup>
24. Promoting health equity calls for policy initiatives in all sectors and at all levels of government.<sup>7</sup>

25. Relative equality in access to material resources, a culture of social solidarity, and fulfillment through contribution are major determinants of population health status.<sup>36</sup>
26. Government policy is driven and constrained by electoral sentiment, cultural currents, interest group pressures, state capture and pressures arising from international economics and geopolitics. Driving towards health equity requires the mobilisation of civil society, the strengthening of democratic participation and institutional integrity, and the pursuit of global governance that upholds health as a universal human right - while working toward a fairer, more sustainable, and more peaceful world, one that embraces the principles of *buen vivir* (well living).<sup>37</sup>

### PHAA seeks the following actions:

27. Governments at all levels, should:
  - a. Guarantee universal access to high-quality, culturally competent, trauma-informed, publicly funded health care, grounded in comprehensive primary health care principles;<sup>38</sup>
  - b. Implement and fund the National Preventive Health Strategy 2021–2030, ensuring it advances equity for priority populations;<sup>39</sup>
  - c. Commit to addressing the risk exposures and vulnerabilities that contribute to health inequities, including commercial influence on health behaviours, environmental harms linked to climate change, early-life inequities, and socioeconomic disadvantage along with other social determinants of health;
  - d. Conduct regular and comprehensive monitoring and reporting – including to state and federal parliaments - on health access, outcomes, and determinants, using disaggregated data to reveal and respond to inequities among population groups;
  - e. Adopt a cross-sectoral approach to policy development for health equity ensuring policy coherence across health care, economic policy, social protection, and social policy;
  - f. Promote intergenerational health equity by improving conditions that shape early development (i.e. education, nutrition, family support) and disrupting cycles of trauma, especially for Aboriginal and Torres Strait Islander peoples;
  - g. Ensure that strategies for addressing health inequities for Aboriginal and Torres Strait Islander communities are developed in accordance with the Priority Reforms identified in the 2020 National Agreement on Closing the Gap: <sup>40</sup>
    - i. Priority Reform 1: Strengthen and establish formal partnerships and shared decision-making
    - ii. Priority Reform 2: Build the Aboriginal and Torres Strait Islander community-controlled sector
    - iii. Priority Reform 3: Transform government organisations so they work better for Aboriginal and Torres Strait Islander people
    - iv. Priority Reform 4: Improve and share access to data and information to enable Aboriginal and Torres Strait Islander communities to make informed decisions;
  - h. Enable meaningful participation of affected communities in the design, governance, and evaluation of health and social policy and services.

28. The Australian Government should:

- a. Ensure taxation and social transfers are progressive, equitable, and adequate to support population health and equity;
- b. Uphold Australia's international commitments to fully implementing the Paris Agreement on climate change,<sup>41</sup> and the 2030 Agenda for Sustainable Development.<sup>42</sup> Require and implement prospective health equity impact assessments for major public policies, with transparent evaluation and accountability;
- c. Align foreign policy - including on trade, immigration, and aid - with global health equity goals;
- d. Fund research into the drivers of health equity and strengthen the evidence base for equitable policy and program development.

29. Civil society, including professional, commercial, educational, cultural, media, legal, community-based, faith-based and union organisations, should:

- a. Identify and reduce practices within their sectors that undermine health equity, and advocate for policies that promote it, including by holding governments accountable;
- b. Disseminate transparent, evidence-based information that supports informed, health-promoting decisions;
- c. Support social and political movements that advance health and societal equity.

### **PHAA resolves to:**

30. Advocate that Australian governments at all levels adopt and coordinate the above actions and hold them accountable for progress on health equity.
31. Promote universal access to comprehensive, high-quality health care through collaboration across the health system and with other health bodies.
32. Strengthen the public health workforce to advance health equity by supporting training institutions and professional bodies to enhance education, advocacy, and practice in this area.
33. Build awareness across the health sector and civil society of the structural causes of health inequities - including disproportionate health risks - and mobilise support for effective policy responses.
34. Work with organisations in and beyond health to build institutional and cultural conditions for health for all, including prevention programs, inclusive communication, transparency, trust, and the reduction of fear, misinformation, and discrimination.
35. Promote meaningful community participation in policy decisions that affect health and wellbeing, with a focus on socially, politically and economically excluded populations.
36. Advocate for further research into health inequities - their causes, impacts and solutions - in Australia and globally.
37. Engage with global, regional, and national organisations to highlight the socio-cultural, economic, environmental, and geopolitical drivers of health inequities, and to advance international action on health equity and the right to health, in line with the Sustainable Development Goals.

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and 2025**

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