

## 5.2 Introduction

This document attempts to quantify the differences in health between Indigenous and non-Indigenous Queenslanders.

Throughout the document, every effort is made to distinguish between the health of Aborigines and Torres Strait Islanders, as these are distinctly different people with different histories and epidemiological transitions.<sup>1,2</sup> In addition, the scope of the document includes an analysis of the health of urban Indigenous peoples. This analysis has been limited by a lack of suitable data.

Comparisons between the health of the population groups were performed using five proxies:

1. Stratification of Queensland into areas by the proportion of Census respondents who identified as Indigenous
2. Indigenous status field from the Queensland Admitted Patient Data Collection
3. Utilisation of the locality field in the above to consider remote Indigenous communities
4. Reference to Australian Indigenous identified data
5. 2001 Census demographic data.

Documents of this nature are essentially Anglo-centric. It is important to note that what the authors of this document (who are indoctrinated into the Western medical model of health) perceive as “health” may not correspond with what Indigenous Queenslanders perceive as “health”.

*“In Aboriginal society there is no such word, term or expression for ‘health’ as it is understood in western society. The word as it is used in Western society almost defies translation, but the nearest translation in an Aboriginal context would probably be a term such as ‘life is health is”*

*National Aboriginal Health Strategy 1989<sup>3</sup>*

For the first time in Queensland, this report compiles a consolidated set of indicators of the major behavioural, social, economic and environmental determinants of health. This report also describes the relationship between the determinants and health outcomes. Health Determinants Queensland provides evidence for investment in population health, both in the health sector and across government. This report identifies priority areas for primary prevention and practical interventions where investments to improve the health of Queenslanders can be made.

### 5.2.1 Social determinants of health

The greatest burden of ill health is borne by those most disadvantaged in Australia. One of the dominant features affecting the health situation of all industrialised countries is the social gradient in health and disease.<sup>4</sup> This gradient in health and disease is prevalent in all socioeconomic strata of society. Specifically this gradient means that the disadvantaged have poorer health than the advantaged, and that among people who are not poor, there is a social gradient in mortality that runs from the bottom to the top in each society.

People of low socioeconomic status, ie. those who are relatively socially or economically disadvantaged, experience worse health than those of higher socioeconomic status for almost every major cause of mortality or morbidity.<sup>5</sup> Moreover, socioeconomic differences in health are evident for both females and males at every stage of the life course. Socioeconomic inequalities in health have been extensively reported for Queensland.<sup>6</sup> Social and economic disparities are one of the major public health challenges confronting Queensland.<sup>7</sup>

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A safe environment, adequate income, meaningful social roles, secure housing, higher levels of education and social support are all associated with better health and wellbeing.<sup>8-11</sup> In addition to health behaviours, these social, cultural, economic and environmental factors comprise what we call population health determinants and are the focus of this report. While each of these influences is dealt with in a separate section of this report, it is the interaction of all these factors that ultimately determines the health of individuals, families and communities.<sup>12</sup>

Access to health services, the ability to act on health advice, and the capacity to modify health risk factors are all influenced by the circumstances in which people live and work.<sup>4</sup> Studies have shown that those

most needing care are least likely to receive it.<sup>13,14</sup> The quality of care received by people with higher socioeconomic disadvantage is different from those with lower levels of disadvantage.<sup>15</sup> In addition, socioeconomically disadvantaged people living in rural or remote areas also have reduced access to some preventive or illness management services. Differential access to ambulance services and travel time to health facilities were associated with higher myocardial infarction mortality rates in rural areas of New South Wales.<sup>16</sup> In 1981-95, mortality rates among working age adults were significantly higher for males and females in the most disadvantaged Local Government Areas in New South Wales, than in the least disadvantaged areas.<sup>17,18</sup>

A wealth of evidence supports the strong association between poverty and ill health.<sup>7,19,20</sup> Income is considered the single most important modifiable determinant of health.<sup>20</sup> In Australia, children living in single-parent households and without both biological parents, or with parents with lower formal education and income, are more likely to experience behavioural and emotional problems as well as physical limitations, than their less disadvantaged counterparts.<sup>21</sup> Socioeconomically disadvantaged and less formally educated adults and the poorly educated experience the highest rates of illness such as cardiovascular disease and diabetes, and the highest prevalence of risky behaviours, such as smoking and hazardous use of alcohol.<sup>22</sup> In addition, income inequality has a significant impact on population health.<sup>23</sup> Specifically, income and wealth inequalities have been correlated with increased all-cause mortality.<sup>24,25,26</sup>

While our socioeconomic position connects us to the physical and social resources that can make our life better, it is also the feelings of empowerment and status that go with the connection to these resources that are important. This second dimension is important as people who feel in control of their lives also are more likely to take control of their health.<sup>27</sup>

A lack of control over work and home life has a powerful effect on our health.<sup>4</sup> Like continuing anxiety, feelings of insecurity and social isolation, the psychosocial impact of a lack of control at home or at work accumulate during life and increase the chances of poor mental health, physiological wear and tear and premature death.

Psychosocial factors affect physical health through the stress response. Although the stresses of modern life rarely demand strenuous or even moderate physical responses, turning on the stress response diverts energy and resources away from many physiological processes important to long term health maintenance.<sup>4</sup> For brief periods, this stress response has minimal impact, however, if people feel tense too often or the tension goes on for too long, they become more vulnerable to a wide range of conditions including infections, diabetes, high blood pressure, heart attack, stroke, depression and aggression. The lower people are in the social hierarchy of industrialised countries such as Australia, the more common these problems become.<sup>4</sup>

While many population health interventions target lifestyle factors where health gains can be made, the social influences on health behaviours must be considered in both the design and implementation of these interventions.<sup>4</sup> The World Health Organisation (WHO) identifies the need to understand the interaction between material disadvantage and social meanings.<sup>4</sup> "It is not simply that poor material circumstances are harmful to health; the social meaning of being poor, unemployed, socially excluded, or otherwise stigmatised also matters."

As well as income and education, other social factors are known to affect the health of populations. For example, unmarried and divorced people,<sup>28</sup> and men have consistently higher age-adjusted death rates than married people and women. Additionally, social trends such as the increase in one-parent families, the ageing population and people starting families at a later age are already influencing the economic environment and the health status of the population.<sup>20</sup>

Ethnicity can also influence health outcomes. Limited service knowledge, poor language skills, employment discrimination,<sup>29</sup> associated low socioeconomic living environment, absence of social networks<sup>30</sup> within minority migrant communities and refugees, and genetic determinants play a role. For example, racial minorities in Britain experience interpersonal violence, institutional discrimination, or socioeconomic disadvantage, all of which have independent detrimental effects on health, regardless of the health indicator used.<sup>31</sup>

Social determinants of health are often beyond the control of the individual. Addressing them through multidisciplinary efforts at the population level can assist in preventing illness and improving the overall health of the community. While universal access to healthcare is one of the social determinants of health, more important to the health of the population as a whole are the social and economic conditions that make people ill and in need of healthcare in the first place.<sup>4</sup>