

Equity in health: An important issue for a sustainable health system

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1. INTRODUCTION

1.1 Background

By world standards residents of Australia and NSW have excellent health and good access to a high quality health system. However these health gains are not shared equally by all population groups in NSW (Draper G et al. 2004, Population Health Division 2004) and it has been estimated that 5,000 lives could be saved each year if we removed these health inequalities (McCracken K 2002).

The differences between those who have the best and worst health in NSW is systematically linked to factors such as where you live, what you do, how much money you earn and how long you stayed at school as well as health risk behaviours and less use of preventive health services. The differences are stark - up to ten years of life is lost for boys between North and South Sydney Local Government Areas; rural people living in disadvantaged areas can also expect to be worse off than people living in more advantaged rural areas (Table 1); and the life of the Indigenous peoples of NSW remains twenty years less than the rest of the population, with one shire recording the average age of death for Indigenous males as 33 years of age (NSW Department of Health 2002, NSW Health 2004, Population Health Division 2004).

Table 1. Life expectancy at birth in NSW, 1994-1998

Area of residence		Boys (yrs)	Girls (yrs)
Rural	Most disadvantaged	66	73
	Least disadvantaged	80	83
Urban	Most disadvantaged	70	79
	Least disadvantaged	80	86

Source: ((NSW Health 2004) p.10)

These patterns of inequality are becoming an increasingly important issue because the burden of disease, mortality risk and rates of hospitalization are concentrated in those parts of the population with the poorest health. Usually people who are living in the most disadvantaged areas of the state who often have the least access to the services they need. This situation leads to higher demands on publicly funded acute health services and long term management of people with advanced disease. Addressing health equity is therefore not only a social justice issue but a central issue in developing a sustainable health system.

1.2 Purpose and focus of this Issue Paper

The purpose of this Issue Paper is to identify actions that NSW Health needs to take over the next three to five years that will lead to a more equitable health system in twenty years. The focus of the paper is on what the NSW health system can do to achieve equity in health at the same time recognising that factors outside of the health care system have a significant impact on equity and inequities in health (McKee 2002, Oldenburg et al. 2000, The Royal Australasian College of Physicians 2005, Whitehead 1995).

In May 2004, NSW Health released the NSW Health and Equity Statement, *In All Fairness*. The Statement identifies six key areas for action: investing in the early years of life,

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increased participation, developing a stronger primary health care system, increased emphasis on regional planning and intersectoral action, as well as increasing capacity within the health system to address health inequality, including increased resources (NSW Health 2004). This Issue Paper builds on the NSW Statement and identifies four key areas for consideration as part of the Future's Planning process: resource allocation, access to high quality care, prevention and early intervention and closing the health gap between the most and least advantaged.

1.3 Clarity of vision

Equity is about equal access to services for equal need, equal utilisation for equal need and equal quality of care for all (Whitehead 1990). An equity approach recognises that not everyone has the same level of health nor level of resources to deal with their health problems and it may therefore be important to deal with people differently in order to work towards equal outcomes (NSW Health 2004) p.6).

The focus of this paper is not on the profound health inequalities experienced by Indigenous peoples in NSW but it is recognised that this is the most important equity issue that needs to be addressed by NSW Health. Also it has not been possible to provide extensive detail on the nature of health inequalities, especially in relation to access to services, in this paper but it is recognised that many rural and remote communities, locationally disadvantaged urban communities, peoples from culturally and linguistically diverse backgrounds and many marginalised groups in our community (such as prisoners, homeless people and refugees) have significant, and often specific issues that need to be addressed.

If a more systematic approach is to be taken to addressing health equity there needs to be a shared understanding of long terms goals (Graham & Kelly 2004). This involves reaching a consensus on whether the main concern is to:

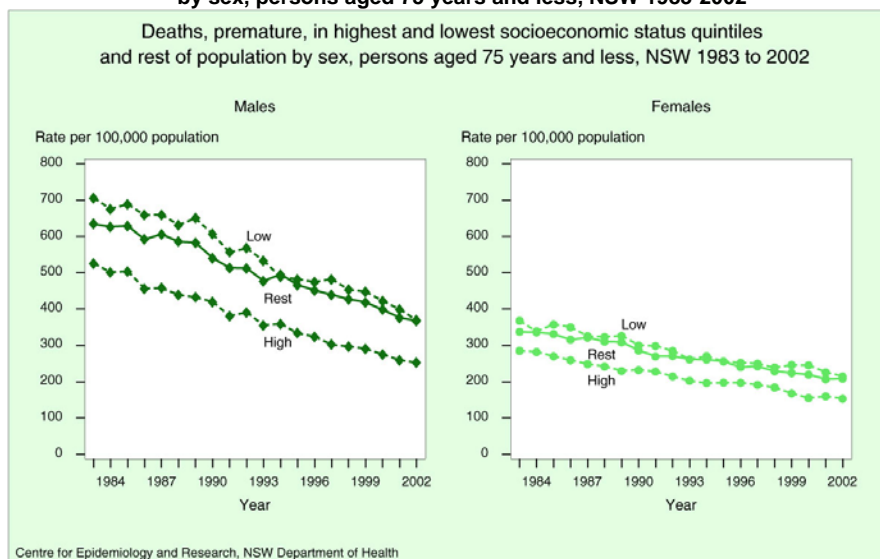
- improve the health of the those with the worst health; or
- improve the health of everyone while at the same time closing the gap between the most and least disadvantaged; or
- address the gradient in health where at a population level more wealth means more health no matter how rich or poor you are (Graham Hilary 2004) (see Figure 1 for an example of the social gradient).

The decision on which approach is adopted is crucial as over time it can lead to very different outcomes. For example, if we were trying to improve the health of those with the worst health we might decide to target services for particular groups to meet major health issues such as low rates of immunisation, high teenage pregnancy rates. If we were interested in making sure that the health of everyone was improving while trying to close health gaps (either between top and bottom or across all groups) the focus might on developing strong universal mainstream services that were responsive to the special needs of specific populations. In NSW recent data suggests that by far the steepest improvements have been among the highest socioeconomic group, resulting in an increase in the relative gap between this group and the rest of the population (Population Health Division 2004).

1.4 A “fully engaged” constituency

Evidence from overseas, Australia and NSW (McKee 2002, Ministry of Health 2002, NSW Health 2004, Oldenburg et al. 2000, The Royal Australasian College of Physicians 2005, Turrell et al. 1999, Wanless 2004, Whitehead 1995) suggest that sustainable gains can be made in addressing health inequality.

Figure 1. Deaths, premature, in highest and lowest SES quintiles and rest of population by sex, persons aged 75 years and less, NSW 1983-2002



Source: (Population Health Division 2004)

However taking action will require reorientation of existing patterns of investment in services and programs within the health sector and government more widely. As part of this NSW Health needs to “fully engage” the:

- **community** in debates on what kinds of health services should be publicly funded, how these services should be funded and whether access to these services should be on the basis on need;
- **government as a whole**, particularly central agencies such as Treasury, who need to support changed patterns of investment and participate in cross- sectoral action to address underlying determinants of poor health; and
- **health workforce** who will need to support action to redistribute resources, change work practices and support the development of new types of health workers.

At the community level people have demonstrated a preference for equity in health care. Australian studies have shown that both citizens and health care professionals agree on the need for greater equity in the health care system (Mooney G 2003).

2. RESOURCE ALLOCATION

Despite the high level of investment by the NSW Government in the health system, inequalities in health between the most and least disadvantaged are increasing in NSW and nationally (Draper G et al. 2004, Population Health Division 2004, The Royal Australasian College of Physicians 2005). These inequalities are thought to be preventable, unfair and worthy of attention by the NSW health system.

An equity approach to resource allocation is concerned at looking at the level of resources and the distribution of these resources in achieving more equitable health outcomes.

2.1 What are the future challenges?

There are four key issues in ensuring equity in resource allocation:

- Failure to proactively address health inequity is putting increased pressure on publicly funded health care systems through inappropriate and unnecessary admissions to hospital and long term management of multiple, complex problems arising from failures of preventive care, early intervention and poor access to allied health services;
- There is increasing evidence that a strong Primary and Community Health (P&CH) system is crucial for addressing health inequalities but the capacity for NSW Health

to develop these systems is limited because they require a mix of Commonwealth and State funded services;

- The major resource of the health system is its workforce. As well as critical workforce shortages that particularly affect disadvantaged areas, there is increased demand to develop different kinds of workforces that may better meet emerging health problems; and
- The restructure of the health system may mask inequalities in the ways in which resources are being allocated and limit the capacity of managers to reallocate resources within Area Health Services (AHS). For example, the merging of Northern Sydney and Central Coast Area Health Services masks a significant difference in the rates of new cases and deaths from lung cancer in the two areas (see Table 2).

Table 2. Differences in lung cancer cases and deaths per 100,000 population within and between Area Health Services, 1996-2000 and 1998-2002.

Lung cancer	1996-2000		1998-2002
	Northern Sydney	Central Coast	Northern Sydney and Central Coast
New cases per 100,000 population	30.2	42.4	37.7
Deaths per 100,000 population	24.5	37.1	32.3

Source: (Population Health Division 2002, Population Health Division 2004)

2.2 What are the health system strengths that can be built on?

NSW Health has a strong base from which to meet these challenges:

- the NSW health system is well resourced and provides excellent care by world standards;
- the RDF has already led to a redistribution of resources and provides a platform for further development;
- there is increased commitment to the development of a strong community based health care and chronic disease management system; and
- the importance of programs for groups with the poorest health (such as Indigenous people, prisoners and refugees) is well recognised.

2.3 What is the long term vision?

By 2020 NSW Health resources will be fairly distributed between AHS and within AHS on the basis of health need.

2.4 What are the key priorities for the next 3-5 years

- Developing funding structures between NSW, the Commonwealth and private sector that will facilitate planning of an integrated health system with a strong primary and community based infrastructure.
- Undertake audits in AHS of patterns of resource allocation within AHS, as well as continued refinement of the state RDF.
- Exploration of the different kinds of workforce that may be needed in the future to address emerging health problems, especially in hard to serve areas.
- Review levels of recurrent investment in Indigenous health services and recommend resource allocation mechanisms that will lead to greatest improvement in Indigenous health.

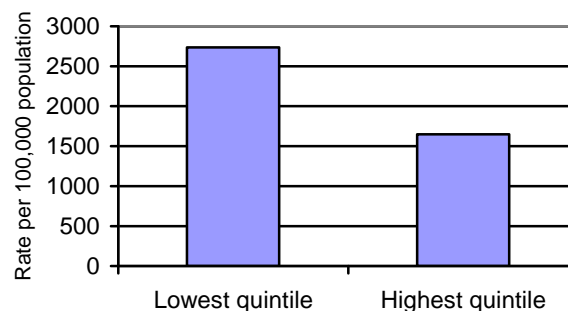
Acting on these key priorities will require full engagement of the community, government and health workforce in developing the detail and to ensure a shared vision about the priorities and rationale for resource allocation and likely redistribution of resources within the system.

3. ACCESS TO QUALITY CARE

Access to quality care is integral to achieving equity in health. Advances in the effectiveness and quality of health care together with a focus on evidence based medicine mean that the contribution that health care can make to health (and health inequalities) is significant (McKee 2002, Or 2000). This includes access to a comprehensive range of primary and community health services as well as hospital based services, especially ones that focus on reaching hard to reach groups as well as providing easily accessible mainstream health services.

The quality, level and range of care provided needs to be related to need. There is some evidence that this is not the case in NSW. While, overall, people from the least advantaged backgrounds use health services (such as hospitals) at the same or greater level than the rest of the population this generally reflects the higher level of illness in these groups (see Figure 2). However it appears that people from the least advantaged backgrounds have less access to preventive health services and early detection programs leading to presentation with more severe and complex health problems. The type of care they receive may also be of a different quality. For example, the length of GP consultation is considered a marker of quality of care but those people from the least advantaged areas have 50% less chance of a long consultation than those in more advantaged areas despite a much higher burden of disease (Furler et al. 2002). Access to specialist and allied health services, important in the management of chronic disease, is also restricted by limited access to publicly funded services.

Figure 2. Hospitalisation for ambulatory sensitive conditions by SES quintile



Source: (Population Health Division 2004)

3.1 What are the future challenges?

- Continued development of a comprehensive, responsive and comprehensive health system that provides services in relation to need to all parts of the NSW.
- Reduction in the barriers to access, especially for those who are most vulnerable, particularly access to prevention and early intervention services.
- Active engagement of patients, carers and the community in decisions about the range of services that should be provided and the ways in which they are involved in care.

3.2 What are the health care service strengths that can be built on?

There is a strong and demonstrable tradition in the NSW Health system that people receive care relative to need. Consistent with the principle of universality, doctors who treat the most advantaged in the community usually also provide services to the least advantaged. Chronic disease initiatives, including the Indigenous Vascular Health Program and the recent proposal to establish Integrated Primary Care Centres reflect the capacity of the system to respond to emerging issues. The NSW Quality Framework has access as one of its six key indicators and Area Health Services are expected to offer equitable access to health services on the basis of need irrespective of geography, socioeconomic status, ethnicity, age

or sex (NSW Health 1999). In addition there is a growing capacity to monitor access to health services and report in a systematic way.

3.3 What is the long term vision?

By 2020 there will be a comprehensive range of high quality community and hospital based services available across NSW that are accessed relative to need. The range of services provided will be determined through the full engagement of the community, other government agencies and the health workforce.

3.4 What are the key priorities for the next 3-5 years?

- Maintain and develop programs that facilitate access to health services by those groups who are most marginalised, including provision of services for culturally and linguistically diverse groups.
- A greater focus on engaging individuals, carers and communities in making decisions about their health and the ways in which they access health services.
- The development of more comprehensive indicators of access to quality care within the NSW Quality Framework with regular reporting within and between AHS.
- Improved access to quality prevention and early intervention services.
- To develop incentives to ensure that staff are recruited and retained in underserved areas.
- Increased integration of state and Commonwealth funded services, such as Integrated Primary Health Care Centres.

Implementation of these key priorities will be a challenge because it will involve redistribution of resources and a change in the types of services that are given priority funding. Here again full engagement of major stakeholder groups, including the media, is required to ensure a shared and sustained commitment to seeing these priorities implemented.

4. PREVENTION AND EARLY INTERVENTION

There is also a growing evidence base for interventions in the early years of life and young adulthood that can promote health development and prevent the development of long term physical and mental health problems, such as depression or cardiovascular disease (NSW Health 2004). To ensure the future sustainability of the health system we need to focus on promoting normal development and preventing risk. Given the evidence around the significant gains from prevention and early intervention, it is important to ensure that **all** young people have equal life opportunities to develop normally and reduce their risk of illness later in life.

The need for this preventive focus is reflected in higher rates of potentially preventable mortality and morbidity in disadvantaged populations. For example, in NSW, in the most disadvantaged quintile of the population, there are 112 primary preventable deaths per 100,000 population compared with 101 per 100,000 in the most advantaged group (Population Health Division 2004). There are also higher levels of behavioural risk factors, such as smoking, in the most disadvantaged groups, who do not seem to respond to traditional health promotion approaches. Developing expertise in tailoring these programs to those with the highest level of risk will be essential. Finally many of the causes and cures of health inequality lie outside the health system and we therefore also need to focus on what can be done in collaboration with other sectors to enhance prevention and early intervention efforts.

4.1 What are the future challenges?

- The systematic under funding of prevention and early intervention programs in NSW and Australia in the past must be urgently addressed. (NOTE: only 2% of health expenditure is allocated to public health programs (Australian Institute of Health and Welfare 2004)).

- Expertise in effective health promotion programs for those populations with the worst health needs to be built.
- Many of the potential health inequalities related to education or income are being masked by the good health of many migrant communities. As migrant communities become more acculturated their health risk profile could increase dramatically.
- It is imperative that the health system raises awareness on the nature and extent of health inequalities and develops strong working relationships with other parts of government, with the private sector and the community to prevent these inequalities developing and managing their consequences.

4.2 What are the health system strengths that can be built on?

NSW is well placed to address these issues. There is a well developed population health infrastructure centrally and within AHS that can provide the basis for reform. Programs such as Families First and the ongoing implementation of the Drug and Obesity Summits have provided positive experience in working with other parts of government, the non-government and community sector and the private sector.

4.3 What is the long term vision?

By 2020 there will be a doubling of the investment in prevention and early intervention programs that have strong commitment and capacity to intervene in ways that will improve the health of the population while reducing the gap between all groups in the community, including those who are most disadvantaged.

4.4 What are the key priorities for the next 3-5 years?

- Increasing overall investment in prevention and early intervention programs and sustain this investment to ensure gains made are preserved.
- Developing skills in working effectively with populations that are currently not benefiting as much from health promotion programs. Suggested areas of initial concentration could be smoking in pregnancy, diabetes prevention and oral health in priority populations.
- Actively working with migrant communities to ensure their positive on-arrival health status is maintained.
- Working with other sectors (eg. the community, the private sector and the health workforce) to address underlying causes of health problems such as poor work safety, insecure food supplies for some groups and improvements in health literacy.

5. REDUCING THE GAP

The gaps in health and life expectancy between the most and least advantaged groups in NSW are potentially amenable to change. Reducing these gaps is not only a social justice issue but also a key imperative in ensuring there is a sustainable health system in NSW.

International and Australian evidence suggests that there are a number of key focus areas where change can occur. As identified these include: investment in the early years of life, increased participation of individuals and communities in addressing health issues, strengthening the P&CH system, increased regional planning and intersectoral action to address underlying determinants of health and building capacity within NSW Health structures and the workforce to lead change. Details of these points of intervention can be found in the NSW Health and Equity Statement and reports from other countries including New Zealand, the UK and the Netherlands (Gunning-Schepers & Gepkens 1996, Mackenbach JP & Stronks 2004, Ministry of Health 2002, NSW Health 2004, The Royal Australasian College of Physicians 2005, Wanless 2004, Whitehead 1995).

5.1 What are the future challenges?

- High level political and community support is required to support changes to patterns of investment. Mobilising sufficient levels of investment to make a difference will be a challenge and will not go uncontested by those with vested interests.
- This investment needs to be linked to a clear understanding of the long term goals – increasing the health of the entire population while reducing the gap between all groups, particularly the most disadvantaged in our community.
- Working with other sectors to address issues of common concern and advocating for action in areas where change will have a positive impact on health because most of the causes of health inequality lie outside the health system.

5.2 What are the health system strengths?

By world standards NSW can be proud of the advances it has made in tackling health inequalities and there is experience in the health system on ways in which this can be done within the health system and in collaboration with other sectors and the community. There are indications that there is community support for an equitable health system and there is widespread professional support for this action (for example (Mooney G 2003, Public Health Association of Australia 2003a, Public Health Association of Australia 2003b, South East Health 2003, The Royal Australasian College of Physicians 2005, Vilshanskaya et al. 2003).

5.3 What is the long term vision?

By 2020 while there continue to be improvements in the health of the whole population the gap between the most and least advantaged groups will be halved. Similarly the gap between Indigenous and non-Indigenous people in NSW will also be halved.

5.4 What are the key priorities for the next 3-5 years?

- Clearly state the goals of action to address health inequality in NSW.
- Systematic intervention in areas that have been demonstrated to be effective as outlined in the NSW Health and Equity Statement.
- Provide strong leadership with other parts of government, the private sector and community to make developing a more equitable society, and therefore a more healthy society, a key priority for government and the community by:
 - Building on existing whole of government approaches to addressing the underlying causes and managing the consequences of health inequality, such as Families First, the work from the Drug and Alcohol Summit, and the NSW Physical Activity Taskforce.
 - Advocating for a cross-cut spending review by Treasury of current levels of investment in reducing health inequality in NSW.
 - Undertaking equity-focused health impact assessment on all major government policies and programs in collaboration with major stakeholders.
- Promoting appropriate representation on Area Health Advisory Councils and the Health Care Advisory Council so that the interests of those with the poorest health and those who are hardest to engage are represented.

6. WHAT ARE THE RISKS OF NOT ACTING?

It is important to debunk the myth that addressing equity is an expensive add-on for the health system. To the contrary, running an inequitable health system has significant costs to the health system, to society and to the individual. Inequalities in health have costs to society through existing health care services (usually at the tertiary or curative end) and future health care system costs due to increasing morbidity. From a socioeconomic perspective, the mortality burden due to socioeconomic inequality “has profound and far-reaching implications in terms of unnecessary loss of life, the loss of potentially economically productive members of society, and increased costs for the health care system.” (Turrell & Mathers 2001) Inequalities limit not only health opportunities but also life opportunities.

But it is not just the differences between the most and least disadvantaged where inequity has an impact. As outlined in Table 3, if in 2004/05, the lowest SES quintile in the NSW population had the same rate of avoidable hospitalisation as the highest, this would save 14,945 hospitalisations at a saving of \$47 million at 2004/05 prices. If, in 2004/05, all the NSW population were to have the same rate of avoidable hospitalisation as the highest SES quintile, this would save 51,720 hospitalisations at a saving of \$162.8 million at 2004/05 prices (NSW Health Department (Inter-government & Funding Strategies Branch) 2004, Population Health Division 2004). This demonstrates importance of acting not only to meet needs of most disadvantaged but also to improve health of all population.

Table 3. Number and costs of additional hospitalisations for ambulatory sensitive conditions (potentially avoidable hospitalisations) associated with socioeconomic status, 2000/01-2004/05

	2000/01		2002/03		2004/05	
	N	\$	N	\$	N*	\$
Lowest quintile same rate highest SES quintile	12,330	29,925,758	14,973	39,347,757	14,945	47,030,405
All population same rate as highest SES quintile	42,151	102,301,465	48,234	126,758,952	51,720	162,763,219

*projected N based on average annual change in number of admissions 1997/98 to 2002/03

Sources: (NSW Department of Health (Funding and Systems Policy Branch) 2002, NSW Health Department (Funding and Systems Policy Branch) 2000, NSW Health Department (Inter-government & Funding Strategies Branch) 2004, Population Health Division 2004)

7. OPTIONS FOR ACTION

Three potential options are:

- **Business as usual:** this is not a 'do nothing' option as there is already significant activity within the NSW Health system to address health inequality. However the recent restructure has highlighted the importance of looking at resource allocation within AHS. There is also pressure on many of the services that we know are important for reducing health inequalities, particularly Primary and Community Health Services and a tendency to address many equity related issues through short term funded projects, such as one-off smoking cessation strategies for particular groups.
- **Taking a pro-poor approach:** this would involve a concerted effort to improve access to health services and other basic social infrastructure for those groups with the poorest health. The strength of this approach is that in times of limited resources there is some certainty that resources would be targeted to those in most need. The weakness of this approach is that without the capacity to mobilise the total resources of the health and other government systems many of the actions that could be taken are then not funded in a sustainable way and are often conceived of as project based actions, such as community gardens in poor areas.
- **An equity-focused system approach:** this would involve recognition of the central role of all parts of the health system, other government and private sectors and the community in ensuring that all people have access to health resources based on need. The strength of this approach is its universal nature which enables us to improve the health of all groups as well as decreasing the gaps between all groups, particularly those most disadvantaged.

We support the third option because it has the potential to address the three key components of an equity approach that is: to improve the health of the most disadvantaged; to narrow the gap between the most and least advantaged; and to reduce the health gaps between all groups in the population.

7.1 Recommendations

The recommendations are outlined at the end of each section and need to be debated and refined further through a process of consultation. However seven major areas have been highlighted by us as the focus for action in the next three to five years and include:

1. Allocating resources in NSW on the basis of need both within and between Area Health Services.
2. Active engagement of the community and health consumers in decisions on the development of health services and the management of health problems.
3. Ongoing and improved monitoring and reporting on patterns of access to quality health services in the Chief Health Officer's Report.
4. Investment:
 - a. Doubling the investment in prevention and early intervention; and
 - b. Focusing on how to work with the most disadvantaged communities in three key areas of early childhood, urban development and chronic disease.
5. Mapping of current levels of investment (between and within Areas) against the strategies for the NSW Health and Equity Statement and negotiating with Areas and with branches in the Department to develop three performance targets for which they will be accountable.
6. Recommending to the NSW Treasury that a cross-cut spending review within NSW from a health inequalities perspective be undertaken.
7. All government departments, including NSW Health, are required to undertake equity-focused health impact assessment of all major proposals including those arising from the Futures Planning Project.

7.2 Questions

1. Should NSW Health have as its equity goal: To improve the health of the people of NSW while narrowing the health gap between all groups, especially between the most and least advantaged.
2. How can we work towards a 'fully engaged' health care system?
3. What are the costs to NSW Health, the government and society in not acting to strengthen equity in the health system?
4. What are the most effective structures that can be put in place to implement any NSW Health strategies to promote equity in the health system?
5. What priority should be given to improving the health of Indigenous people in NSW and reducing the gap?

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