

Health policy and its impact on poverty

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Abstract

Poverty may be defined narrowly as a lack of income, but is more usefully viewed as a multidimensional concept. I discuss some associations between poverty and health, identify groups with special needs, and describe some aspects of the government's health policy which are relevant to those needs. Finally, I note the importance of ensuring there is a more integrated approach in future.

Defining poverty

There is no universally accepted definition or measure of poverty. The dominant definition is *lack of adequate income*, either in relative or absolute terms.

There is also a view of poverty as a more amorphous, *multidimensional concept*. King (1997) says that:

... poverty is most commonly described in terms of income, where income poverty refers to the situation where a family's or person's income is not enough to allow them to achieve a basic standard of living. It is often used as a surrogate measure for all dimensions of poverty, on the basis that people's incomes provide a good, if imperfect, indicator of their standard of living.

By defining poverty specifically in terms of inadequate income, we allow ourselves clarity in our discussions of poverty and, to a large extent, improve our ability to monitor patterns of inequality and disadvantage. Measures of relative income poverty have proven particularly useful for developing policy to alleviate poverty.

However, we should not lose sight of the significance of the broader aspects of poverty in Australia. In its broadest sense, poverty is about the ability to maintain a decent standard of living. It is about lost opportunities – the causes and consequences of unacceptably low living standards.

The Australian Institute of Family Studies (Brownlee 1990) has identified at least 14 distinct living standard areas that contribute to individual or family living standards. They include ‘health’, as well as economic resources, employment, housing, education, recreation, the physical environment, community services and transport. Other dimensions relate to alienation or community participation, like social and political participation, access to information, family relationships, and personal well-being. These factors are particularly relevant when considering the impact of health policy on poverty, and also when considering the effectiveness of health policies in addressing the needs of the poor.

Government departments like Health and Aged Care and Family and Community Services have a broader function to develop and deliver policies that offer what international organisations like the OECD refer to as *social protection*. The OECD (1988) suggests that:

... the objective of social protection must be to ensure each member of society has the possibility of an active role in that society. For most people, most of the time, this would be achieved through their own work and social activities. The role of public policy in the 1990s must be to design interventions so as to maximise both the number of people who have opportunities for active social roles, and the duration of their lives over which they can experience such activity.

The theme of an *active society* adopted here and by the OECD is an important guiding principle for policy-makers. To put it simply: we are in the business of improving the living standards of Australians, whether it be their health or income or another element of their living standards, to ensure that they are empowered and have the opportunity to participate in Australian society.

The objective of empowerment includes an element of mutuality. Government responsibility to facilitate empowerment and participation has increasingly been matched by an expectation that people accept and take responsibility for their affairs and seek to improve their situations. However, we can only expect participation to occur if the underlying socio-economic conditions facilitate it, and if there is wider ‘social capital’ through strong supporting relationships in communities, including from families and business.

From the perspective of the policy-maker, both definitions are useful. The definition of poverty in terms of a lack of adequate income provides an element

of clarity in research and a useful tool for monitoring patterns of disadvantage. The definition of poverty as a multidimensional concept provides a better understanding of the enormity of the disadvantage some members of our community face, and the scale of the challenge we face as policy-makers.

Relationships between poverty and health

The causes of illnesses are complex. To some extent, people get sick because of factors that are really beyond the control of anyone: such as genetic factors or advancing age, or the essentially random incidence of certain ailments and injuries. But there are lifestyle and socio-economic factors and aspects of the physical environment that contribute to illness. The influences on health of socio-economic factors, in particular, are often beyond individual control.

Health inequalities related to social class or socio-economic status have been established in all countries that collect the data. For example, the Australian Institute of Health and Welfare (1992) has reported that Australian males aged 25–64 years in the lowest decile of occupational prestige had a death rate 2.2 times higher than that for the highest decile, and males aged 25–64 years living in areas classified into the worst quintile of socio-economic disadvantage had death rates 68% higher than those in the least disadvantaged quintile.

Of the socio-economic factors discussed in the literature, education and income are the most often associated with health. We know that *education* is a strong predictor of morbidity in Australia. Individuals with higher levels of education report fewer serious chronic and recent illnesses and better mental health than those with lower levels of education, even when controlling for the effects of other socio-economic factors (National Health Strategy 1992). Relatively poorly educated men are 23% more likely to have serious chronic illnesses and 90% more likely to perceive their health as only fair or poor, and relatively poorly educated women are 15% more likely to have serious chronic illnesses and twice as likely to perceive their health as only fair or poor.

To some extent this pattern reflects the relationship between education and income, where education can be an indicator of income and/or wealth. But it is also evident that education can mean an increased capacity to assimilate information, access health services, and make better decisions about lifestyle factors influencing health. There is evidence that the education of women is particularly important in improving health outcomes for children and families, especially in developing countries.

On a world scale, the *gap between the incomes of the rich and the poor* is acknowledged as being the single most important predictor of health status

(Mathers 1994). Australians living on low incomes experience poorer health, and are more likely to suffer disability, serious chronic illnesses, or report recent illness (National Health Strategy 1992). Men and women in low income families report much worse self-perceived health status than adults in higher income families: reports of fair or poor health are 2.7 times more frequent for men and 2.5 times more frequent for women.

Research by the AIHW (Mathers 1994) indicates that people in low income families report substantially more hospital episodes, outpatient visits and doctor visits. However, they are more likely to delay seeking medical treatment, and use fewer public health and preventive, early intervention, screening, rehabilitation and aftercare services.

The literature suggests that income can influence health indirectly and directly (National Health Strategy 1992; Mathers 1994). Low income can lead to reduced social participation, alienation, and then to poor health. Low levels of social support can make it difficult to combat stress and reduce immunity to illness.

Low income is also related to behavioural factors which are themselves health risks. For example, people living on low incomes are more likely to engage in high-risk activities that contribute to poor health (Mathers 1994). They include smoking (41% higher) and low physical activity (30–40% higher). Low income can also be related to employment in occupations that are more physically demanding and carry greater risks of injury.

The direct impact of low income on health is fairly obvious. Health inequalities may arise from low income through the associated inability to purchase goods and services that directly influence health, such as nutritious food and good housing. Family income has been shown to be significantly associated with poor health, even when factors such as education, family composition, workforce status and risk factors (such as smoking and age) were held constant.

While low income can directly or indirectly cause poor health, it can also be the result of poor health. For example, a person with a substantial illness or disability can have increased difficulty in providing for himself or herself, which can lead to a lower level of income. The costs of disability can also be substantial. For many individuals, these effects can lead to a downward spiral: reduced economic resources mean a poorer quality of life which, in turn, impacts on their illness or disability, and so on.

Disadvantages like low income, insecure employment, poor housing and poor health are cumulative. Accordingly, they tend to concentrate among the same people.

They do not just appear together, but they also have the potential to replicate and reinforce themselves over time. Much has been written about the effect of welfare cycles. To the extent that low income and poor health are related, it is evident that, where cycles of relative income poverty exist, there is also a potential for cycles of poor health.

There is no easy solution to income-related poverty: social security and tax policies must take account of incentive effects and wider economic impacts as well as the apparent first round redistribution those policies achieve. Equally, I am very conscious that the health problems of low income groups and other alienated sections of society will not be solved by simply calling on the government and the Department of Family and Community Services (formerly Social Security) to fix income-related poverty.

Groups with special needs

It is no coincidence that poor health is more common among the most marginalised groups within our community. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life have powerful effects on health. For many groups, low income is one element in a more complex pattern of disadvantage.

Indigenous Australians are very much poorer, on average, than non-indigenous Australians, whether they reside in rural and remote areas or urban areas. Despite improved access to health services in the past two decades, their health status still rates worse than that of non-indigenous Australians on every indicator: life expectancy, maternal mortality, infant mortality, childhood morbidity and adult mortality.

For example, in 1992–94, life expectancy at birth in Western Australia, the Northern Territory and South Australia was approximately 14–18 years lower for indigenous males and 16–20 years lower for indigenous females than for their white Australian counterparts (AIHW 1998). Aboriginal men die at 3.5 times the rate of non-Aboriginal men, and Aboriginal women at 4 times the rate of non-Aboriginal women. Deaths from infectious/parasitic diseases are 14.7 times higher for men, and 17.6 times higher for women from indigenous backgrounds. After adjusting for age, death rates are higher for indigenous Australians both overall and for almost every specific cause of death, and their patterns of hospital use are about twice the rate of the rest of the population.

Despite this profile of poor health status, indigenous Australian's access to mainstream primary health care programs is very limited (AIHW 1998). On a per capita basis, they use Medicare and the Pharmaceutical Benefits Scheme at just 25% of the rate of non-indigenous Australians. This is offset by their access to Aboriginal Medical Services and their use of State and Territory hospitals and health services, but overall spending on their health is only 8% higher than that of non-indigenous people, despite their far greater health needs.

Although the gap between the health of indigenous and non-indigenous people has not generally declined, the health of indigenous Australians has improved. For example, death rates from all causes declined among indigenous males by an estimated 1.5% per year between 1985 and 1994 (AIHW 1998). There have also been reductions in infant and maternal mortality figures: the infant mortality rate has fallen from about 20 to about 4 times the non-indigenous rate. Nevertheless, addressing the gap between indigenous and non-indigenous health remains the single most important priority for my department.

People with disabilities frequently lack many of the basic material and cultural resources needed to sustain a healthy existence and social participation. It is widely recognised that they must bear extra costs that people without disabilities do not have (Cass, Gibson & Tito 1988).

Disability-related poverty exists in terms of employment exclusion, shortages of social services, income deprivation from exclusion from the labour force and the extra costs of disability, and the barriers to social participation associated with many types of disabilities. Generally, as the severity of handicap increases, the main source of income change from wages and salary to government pensions or benefits.

The *unemployed* also have special needs. It has been widely reported internationally that unemployment is harmful to health and is associated with health inequalities. Unemployment puts a person's health at risk. The higher incidence of poorer health has been linked to both the financial consequences of unemployment and the psychological consequences – such as a reduced sense of self-worth.

The results of the National Health Survey demonstrated that, irrespective of the impact of income levels, unemployment is independently associated with poorer health. It is therefore of considerable concern that people living on low incomes, adjusted for family needs, are increasingly made up of Australians of workforce age, and in particular the unemployed.

Finally, there are the *homeless*. Adequate housing is an important prerequisite for a healthy life. Poor living conditions lead to increased stress, social isolation, and

an unhealthy and unsafe environment and increased susceptibility to disease or injury. Homeless people frequently demonstrate additional barriers to participation such as disability and negligible levels of income. There are also difficulties in delivering health services and health promotion programs and messages to them.

Relevant activities of the Commonwealth Department of Health and Aged Care

The Australian health care system offers a range of programs to all Australians. There are additional programs designed to offer special assistance to groups in particular need.

Let me first address *Medicare*, and the reform directions we are pursuing. There is now bipartisan support for a universal health system funded by government. The reasons for this bipartisan support are more than political. They concern the fundamentals of health economics in that they recognise:

- the public good in aspects of health, particularly public health
- the asymmetry of information, and the associated reliance all of us place on the professionals in health
- the difficulties in managing moral hazard (when a third party insurer pays the cost, then both the provider and the consumer have a common interest in maximising the level and quality of service)
- the importance of ensuring people do not have to pay more than they can afford, particularly when they are sick.

However, there are differences between the political parties with respect to the extent to which higher income people might contribute towards costs, or should have choice for services beyond those provided on a universal basis by Medicare.

There are also important weaknesses in Medicare which have been recognised by the major political parties. In particular, it focuses more on inputs and providers, rather than on outcomes and consumers. We reimburse people for the costs of medical services, effectively paying the doctors although we have no knowledge of the ailment or whether the service worked. We pay similarly for pharmaceuticals and hospital care without any direct test of outcomes, and there is very little capacity to assess the combined impact of different services for an individual with a particular health condition.

There are a range of initiatives now under way to see if we can make Medicare not just a health financing system but a patient-oriented health care system, and

a population-oriented health outcomes system. The much-maligned Health Care Agreements with the States and Territories will, in fact, provide a major opportunity to pursue this direction. For the first time, they will specify output targets for numbers of hospital services, while also setting out a framework under which the Commonwealth and States/Territories can pool money across programs – on our MBS and PBS and their hospitals' money – if we can identify better ways of treating particular patient groups or providing particular services. This capacity, which we call 'Measure and Share', is a critical development in our health system.

It builds on another initiative, the *Coordinated Care Trials*. These are aimed at people with complex or chronic conditions, involve pooling funds, and employ care coordinators for the patients who can assist in ensuring they have appropriate and the most effective care. Within the available funds, there is no particular restriction on the services that might be provided. The trials cover groups such as diabetics, and the frail aged and also, interestingly, Aboriginal communities. They are intended to test whether we can indeed provide better health care within our current budgeted funds.

The recent Review of the *General Practice Strategy* has also identified options that might reward general practitioners for quality services, not just quantity of services, including prevention measures and continuity of care. The review has also made suggestions to strengthen linkages between general practitioners in joint practices and in Divisions of General Practice, and to improve their linkages with hospitals.

Divisions of General Practice are already being supported to address the needs of their specific communities through funded programs of activity based on a detailed assessment of the needs of disadvantaged groups in their area; providing a network of peer support; and providing a corporate focus for consultation with other sectors of the health and community services system as well as consumers. These initiatives are demonstrating the capacity to blend the advantages of our fee-for-service system with population approaches, on both a geographic and disease group basis.

As we go down this path, there will be increased opportunity to identify and address groups and communities with inadequate access to health services, including, for example, people in rural areas and disadvantaged areas. And with improved information management, we can deliver better care and more effective integrated care.

Public health strategies are designed to prevent illness, promote well-being and provide the basic health infrastructure such as clean air and water needed by all.

While they are vital in improving the health of the community, they must be supported by independently acting on circumstances such as low income, which underlie many health problems.

The World Health Organization (1998) recently identified 10 interrelated aspects of the social determinants of health that must be addressed in order to provide a framework for higher standards of health. They relate to:

- the need for policies to prevent people from falling into long term disadvantage
- the importance of an understanding of how the social and psychological environment affects health
- the importance of a good environment in early childhood
- the impact of work on health
- the problems of unemployment and job insecurity
- the role of friendship and social cohesion
- the dangers of social exclusion
- the effects of alcohol and other drugs
- the need to ensure access to supplies of healthy food for everyone
- the need for healthier transport systems.

These dimensions must be addressed by social protection policies and reflected in public health initiatives in order to ensure that each member of society has the possibility of an active role in that society.

In recent years there have been several significant measures to strengthen our public health system. A major initiative has been the National Public Health Partnership which is addressing the infrastructure we need – such as surveillance, and our regulation framework – as well as specific areas of health promotion. The partnership has also been complemented by Public Health Outcomes Funding Agreements between the Commonwealth and the States and Territories.

Recent Commonwealth Budget initiatives also include:

- measures to reverse the low level of immunisation of Australian children (one of the most important investments in the future any country can make)
- strategic initiatives in the areas of injury prevention, cancer control, and men's health
- a National Environmental Health Strategy to improve assessment, prevention, control and management of environmental health hazards

- commitment of \$214.6 million over five years towards the implementation of the new National Illicit Drug Strategy
- commitment of \$6.1 million over three years for the implementation of tobacco harm minimisation initiatives, including a national response to passive smoking and tobacco education programs which aim to help reduce the number of Australians smoking and to minimise the harms caused by tobacco consumption.

Each will be targeted to address the disproportionate burden on Australians living on low incomes.

In future, health promotion strategies will not only draw more heavily on general practitioners in line with directions identified in the Review of General Practice Strategy, but also on community settings. Effective strategies will come about through changing structures and processes in such settings as schools, workplaces and the neighbourhood.

Equipping people to deal with the forces that impact on their lives is in fact an essential component of health promotion. This involves much more than the simple provision of information.

We also need to understand more clearly the relationship between socio-economic status and morbidity/mortality, including an understanding of mediating factors and what can be done to intervene effectively in the Australian setting. To this end, my department is funding a National R&D Collaboration on Socio-Economic Status and Health which will facilitate and support a collaborative work program at the national level in Australia on the issue of socio-economic status and health.

The department is also funding a national project to map, monitor and report on the burden of disease in Australia, with particular reference to that borne by particular sub-groups, and to the burden of disease attributable to social and economic disadvantage. This is a very exciting development which will bring together information on the cost-effectiveness of health interventions and the potential for health gains in various population groups.

Indigenous health programs provide an example of the targeting of groups facing special disadvantage. For indigenous people, in particular, cultural and structural factors affect health outcomes as well as affecting and being affected by income status. In remote communities there are major difficulties around administration of the PBS and MBS that impact on access to health services, including difficulties in keeping records of eligibility for Medicare and pharmaceutical benefits.

Most importantly, services must have a high degree of community control if they are to be effective. The most important services in many of these communities concern public health – dealing with environmental issues of water, power and housing, and behavioural issues such as nutrition, smoking and alcohol. These require not just money, but a culturally appropriate approach.

Within my department, we are well aware of the gaps in our major programs in responding to the needs of indigenous communities, and see the Aboriginal and Torres Strait Islander Health Program with its focus on community control as critical to overall success. Recent increases in funding are welcome, and will be directed to expand services, particularly those that have a proven success and capacity to do more.

Equally important, we now have Strategic Framework Agreements with the States and Territories, the Aboriginal and Torres Strait Islander Commission and the community-controlled health sector to pursue improvements through integrated planning and development. These agreements are linked also to a framework of clear goals and targets against which all governments will have to report.

The future

The causes of ill health are complex. Illness can be attributed to genetic, social and economic, environmental and lifestyle factors, as well as access to services. There is abundant evidence of the need to address environmental factors such as low relative income in order to improve the health of the community and stop cycles and spirals of disadvantage.

However, health is also determined by other aspects of poverty including poor education, lack of work and social alienation. Empowerment and social participation are key aspects of any policy aimed at improving the health of low income groups. In this context, the concept of mutual obligation – of rights, obligations, and duties – is not necessarily a socially conservative concept but a constructive one that recognises the importance of belonging, sharing roles in our communities, and of mutual support.

One of the areas in which we, as social policy agencies, have not been entirely successful over the last decade has been the integrated delivery of social protection policies. We are in the business of improving opportunities for social participation by all Australians, but we have each focused on addressing separate dimensions of the broad concept of poverty to improve living standards.

This is inevitable to some extent, given the complexity of a concept like poverty and the size of our respective responsibilities. However, one of the inescapable conclusions of any discussion about poverty is that its multidimensional nature may best be overcome in an integrated or holistic way.

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