# Week 3: Inequalities and inequities in health

Welcome to Week 3. This week we move onto the underlying drivers of contemporary public health issues. We start by exploring health and social data to understand the differences in health among and within population groups, referred to as health inequalities or disparities. We will discuss inequality of access, opportunity and outcomes, and consider the relationship between inequalities and inequities as drivers of public health issues.

This week you will also be introduced to the social gradient. We will unpack the relationship between positions on the social gradient, health inequalities and life expectancy. To conclude the week, we will critically reflect on the role of work and the social gradient. This will provide a strong foundation for next week when we move onto unpacking the causes of health inequalities and inequities of contemporary public health issues by examining the determinants of health.

## Outcomes

By the end of this week, having completed the readings and all activities, you will be able to:

**Topic 1: Health inequalities and disparities**

- Interpret health data to demonstrate an understanding of health inequalities and disparities.
- Differentiate between inequality of access, opportunity and outcome.

**Topic 2: Equity and inequity**

- Explain the relationship between inequity and health inequalities and disparities in relation to public health issues.

**Topic 3: The social gradient and health**

- Appraise and reflect critically on health inequalities in life expectancy in relation to the social gradient.

**Topic 4: The social gradient, health inequalities and work**

- Critically reflect on the role of work in relation to the social gradient and health inequalities.

### Estimated learning hours

You will need to spend around 20 hours in total studying and completing activities this week.

### Weekly tutorial

The tutorials give you the opportunity to interact with subject matter experts in real time. These sessions are offered throughout the study period and are considered to be an essential part of the learning activities.

We recommend that you attend the sessions; however, if you are unable to do so, it is essential that you view and/or listen to the recording. Recordings and session notes are typically available after the final zoom session for the topic has taken place.

Below are links to the various topics in this week of learning. Click on Topic 1 to get started with the learning for this week. If you have already started this week of learning, you can resume your studies at any of the below.

Arrows at the bottom of the topic pages will take you to the next page within a topic, or the next topic. Otherwise you can return to this weekly landing page or the home page of this subject by using the tiles on the navigation bar on the left of this site.

Good luck with your studies this week!

Your progress

- Topic 1: Health disparities and inequalities
- Tools for examining health inequalities
- Topic 2: Equity and inequity
- Topic 3: The social gradient and health
- Topic 4: The social gradient, health inequalities and work
- Summary and checklist
- Materials students week3

# Week 3 Glossary

## Burden of disease

A measurement of the gap between a population's current health and the optimal state where all people attain full life expectancy without suffering major ill-health. Burden of disease analysis enables decision makers to identify the most serious health problems facing a population. Loss of health in populations is measured in disability-adjusted life years (DALYs), which is the sum of years of life lost due to premature death and years lived with disability. Burden of disease data provide a basis for determining the relative contribution of various risk factors to population health that can be used in health promotion priority setting. For instance, smoking, undernutrition and poor sanitation are related to a number of major causes of morbidity and mortality and therefore each is a potentially important focus for health promotion. In addition, burden of disease studies can reveal disparities in health within populations that indicate underlying social inequities that need to be addressed.

**Reference:** Modified definition from World Health Organization 2000 cited in Smith, BJ, Tang, KC & Nutbeam, D 2006, 'WHO health promotion glossary: New terms', *Health Promotion International*, vol. 21, no. 4, pp. 340–345.

## Health equity

Providing everyone with the resources they individually need to enjoy full and healthy lives. It differs from equality, which provides the same resources to everyone regardless of need.

**Reference:** Liamputtong, P 2019, *Social determinants of health*, Oxford University Press, South Melbourne.

The rights of people to have equitable access to services on the basis or need, and the resources, capacities and power they need to act upon the circumstances of their lives that determine their health.

**Reference:** Keleher, H & MacDougall, C 2016, *Understanding health*, 4th edn, Oxford University Press, South Melbourne.

## Health gradient

A perspective that examines the health differences across the whole spectrum of the population; it acknowledges systematically patterned gradient in health inequities using measures of social stratification called equity stratifies.

**Reference:** Keleher, H & MacDougall, C 2016, *Understanding health*, 4th edn, Oxford University Press, South Melbourne.

## Health inequality

An observable, often measurable difference in health status between individuals, groups of populations, whatever the cause.

**Reference**: Keleher, H & MacDougall, C 2016, *Understanding health*, 4th edn, Oxford University Press, South Melbourne.

A generic term designating differences, variations, and disparities in the health of individuals and groups.

**Reference**: Kawachi, I, Subramanian, SV & Almeida-Filho N 2002, cited in Kindig, D 2007, 'Understanding population health terminology', *Milbank Quarterly*, vol. 85, no. 1, pp. 139–161.

Differences in health status or in the distribution of health determinants between different population groups. Some are attributable to biological variations or free choice, and others to the external environment and social conditions outside the control of individuals. In the latter case, they may be unnecessary and avoidable as well as unjust and unfair, and thus cause or reflect health inequity. Health inequalities have been documented since at least the analyses of the vital statistics of England and Wales by William Farr.

**Reference:** Porta, M & Last, JM 2018, *A dictionary of public health*, 2nd edn, Oxford University Press.

## Health inequity

Health is a universal human aspiration and a basic human need. The development of society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage due to ill-health. Health equity is central to this premise: Strengthening health equity — globally and within countries — means going beyond contemporary concentration on the immediate causes of disease.

**Reference**: Marmot, M 2007, 'Achieving health equity: From root causes to fair outcomes' *The Lancet,* vol. 370, no. 9593, pp. 1153–1163.

Those inequalities in health deemed to be unfair or to stem from some form of injustice. The dimensions of being avoidable or unnecessary have often been added to this concept.

**Reference**: Kawachi, I, Subramanian, SV & Almeida-Filho, N 2002, in Kindig, D 2007, 'Understanding population health terminology' *Milbank Quarterly*, vol. 85, no. 1, pp. 139–161.

Systematic health inequalities that are a result of modifiable social and economic policies and practices that create barriers to opportunity.

**Reference:** Porta, M & Last, JM 2018, *A dictionary of public health*, 2nd edn, Oxford University Press.

## Health outcome

A change in the health of an individual or population due wholly or partly to a preventive or clinical intervention.

**Reference**: Australian Institute of Health and Welfare 2018, *Australia's health 2018,* viewed 21 January 2021 < www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents >

A health-related change due to a preventive or clinical intervention or service. (The intervention may be single or multiple, and the outcome may relate to a person, group or population, or be partly or wholly due to the intervention.)

**Reference**: Australian Institute of Health and Welfare 2018, *Australia's health 2018*, viewed 21 January 2021 < www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/table-of-contents >

Health status, sometimes related to the effects of health care or other interventions.

**Reference**: Guest, C, Ricciardi, W, Kawachi, I & Lang, I. (eds) 2013, in *Oxford handbook of public health practice,* 3rd edn, Oxford Medical Publications, Oxford.

All the possible results that may stem from exposure to a causal factor from preventive or therapeutic interventions; all identified changes in health status arising as a consequence of the handling of a health problem.

**Reference**: Last, JM 2001, *A dictionary of epidemiology*, 4th edn, Oxford University Press, New York.

Any or all of the possible results that can stem from exposure to a causal factor or from preventive or therapeutic interventions; all identified changes in health status that result from the handling of a health problem.

**Reference**: Centers for Disease Control and Prevention 2012, *Principles of epidemiology in public health practice. An introduction to applied epidemiology and biostatistics*, 3rd edn, viewed 21 January 2021 < www.cdc.gov/csels/dsepd/ss1978/lesson1/section11.html >

## Population, population group

Population refers to a group of individuals, in contrast to the individuals themselves, organized into many different units of analysis, depending on the research or policy purpose.

**Reference:** Kindig, D 2007, 'Understanding population health terminology', *Milbank Quarterly*, vol. 85, no. 1, pp. 139–161.

The number of people in a given area. This can be defined geographically or politically, as in a country, although physical boundaries are not always necessary, as when referring to groups of people sharing common characteristics, for example, ethnicity, religion.

**Reference:** Young 1998, in Kindig, D 2007, 'Understanding population health terminology' Milbank Quarterly, vol. 85, no. 1, pp. 139-161.

All the inhabitants of a country or other designated region. In public health sciences, especially in epidemiology, many subsets of the entire population are identified and selected for intervention and study. Such a group is called target population.

**Reference:** Porta, M & Last, JM 2018, *A dictionary of public health,* 2nd edn, Oxford University Press.

Governments, communities, organisations and researchers are interested in the wellbeing outcomes of different groups of people. Some of these groups may face greater challenges in accessing the same opportunities as others in the community. These challenges might be related to a range of environmental, socio-economic, personal or physical factors, or a combination of factors.

Information on particular groups of people with similar characteristics helps in better understanding their challenges and how to improve access to opportunities for those who are most vulnerable. [***Editor's note***: Examples of population groups of interest are: people living in regional and remote areas, people with mental health disorders, people who are caring for others, Aboriginal and Torres Strait Islander peoples, people experiencing socio-economic disadvantage, migrants, women, young people, older people, people in single parent families (parents and children), people who are unemployed, people who have been victims of crime, homeless people.]

**Reference**: Australian Bureau of Statistics (ABS) 2015, *Frameworks for Australian Social Statistics, Jun 2015*, cat. no. *4160.0.55.001,* viewed 21 January 2021, <www.abs.gov.au/ausstats/abs@.nsf/Lookup/4160.0.55.001main+features10019Jun+2015>.

## Social gradient of health

The poorest of the poor, around the world, have the worst health. Within countries, the evidence shows that in general the lower an individual's socioeconomic position the worse their health. There is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. This is a global phenomenon, seen in low, middle and high income countries. The social gradient in health means that health inequities affect everyone.

For example, if you look at under-5 mortality rates by levels of household wealth you see that within counties *(sic)* the relation between socioeconomic level and health is graded. The poorest have the highest under-5 mortality rates, and people in the second highest quintile of household wealth have higher mortality in their offspring than those in the highest quintile. This is the social gradient in health.

**Reference**: World Health Organization. (n.d.), *Key concepts*, viewed 21 January 2021 < www.who.int/social_determinants/thecommission/finalreport/key_concepts/en >

The health advantages and disadvantages experienced by Australians are shaped by their broader social and economic conditions. Inequalities in health appear in the form of a 'social gradient of health', so that in general, the higher a person's socioeconomic position, the healthier they are. Some health inequalities are attributable to external factors and to conditions that are outside the control of the individuals concerned. Inequalities that are avoidable and unjust — health inequities — are often linked to forms of disadvantage such as poverty, discrimination and access to goods and services (Whitehead, 1992).

**Reference:** Whitehead 1992, cited in Australian Institute of Health and Welfare 2016, *Australia's health 2016,* viewed 21 January 2021 < www.aihw.gov.au/getmedia/9844cefb-7745-4dd8-9ee2-f4d1c3d6a727/19787-AH16.pdf.aspx?inline=true >