



Income inequalities and health in Australia

– response to Kawachi presentation

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**Discussant at the Australian Health Policy Institute seminar:
'Differences in Income are a Health Hazard'**

University of Sydney, 8 June 2005



Structure of presentation

The two main issues covered are:

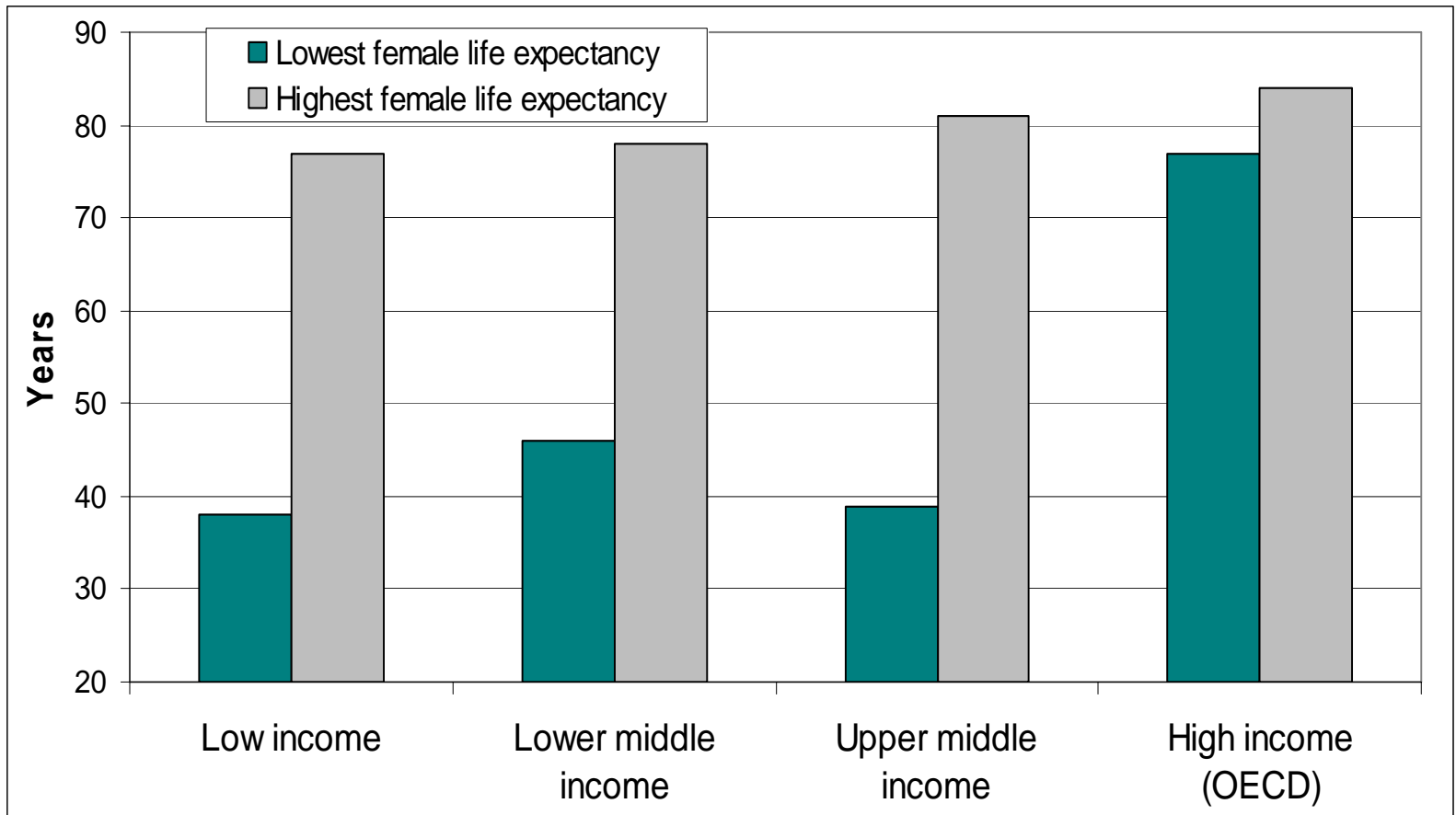
- *A: whether health differentials by socioeconomic status (SES) are large enough for policy attention?*
- *B: whether 'interventions' to date have been successful, and*
 - if yes, what were the key elements contributing to success



A: are health differentials by socioeconomic status (SES) small?

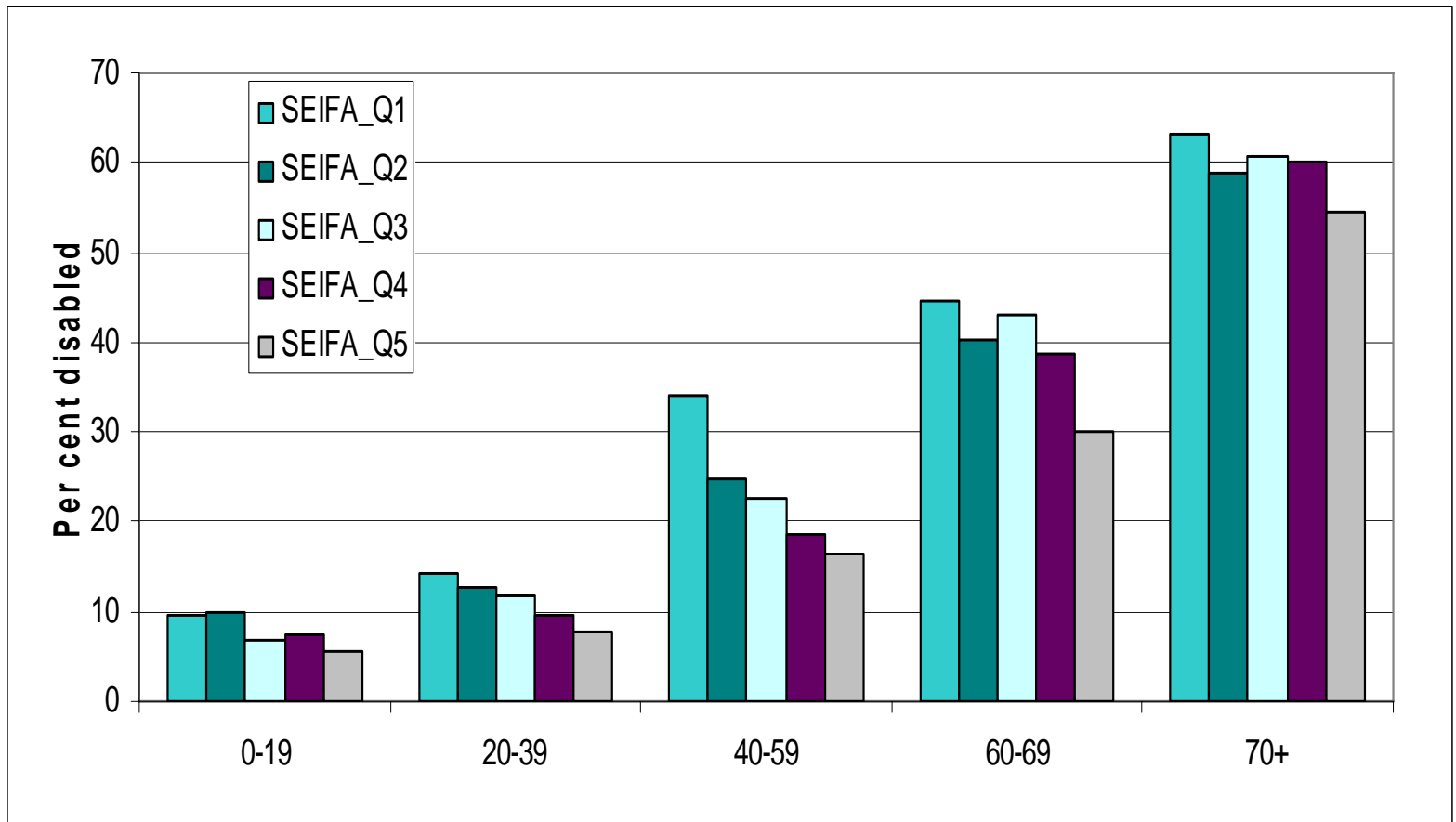
(A1) Some measures of SES may indicate greater/lesser inequalities in health than others

(1a) Life expectancy by income - world (Walker et al, WHO Kobe report, 2003]

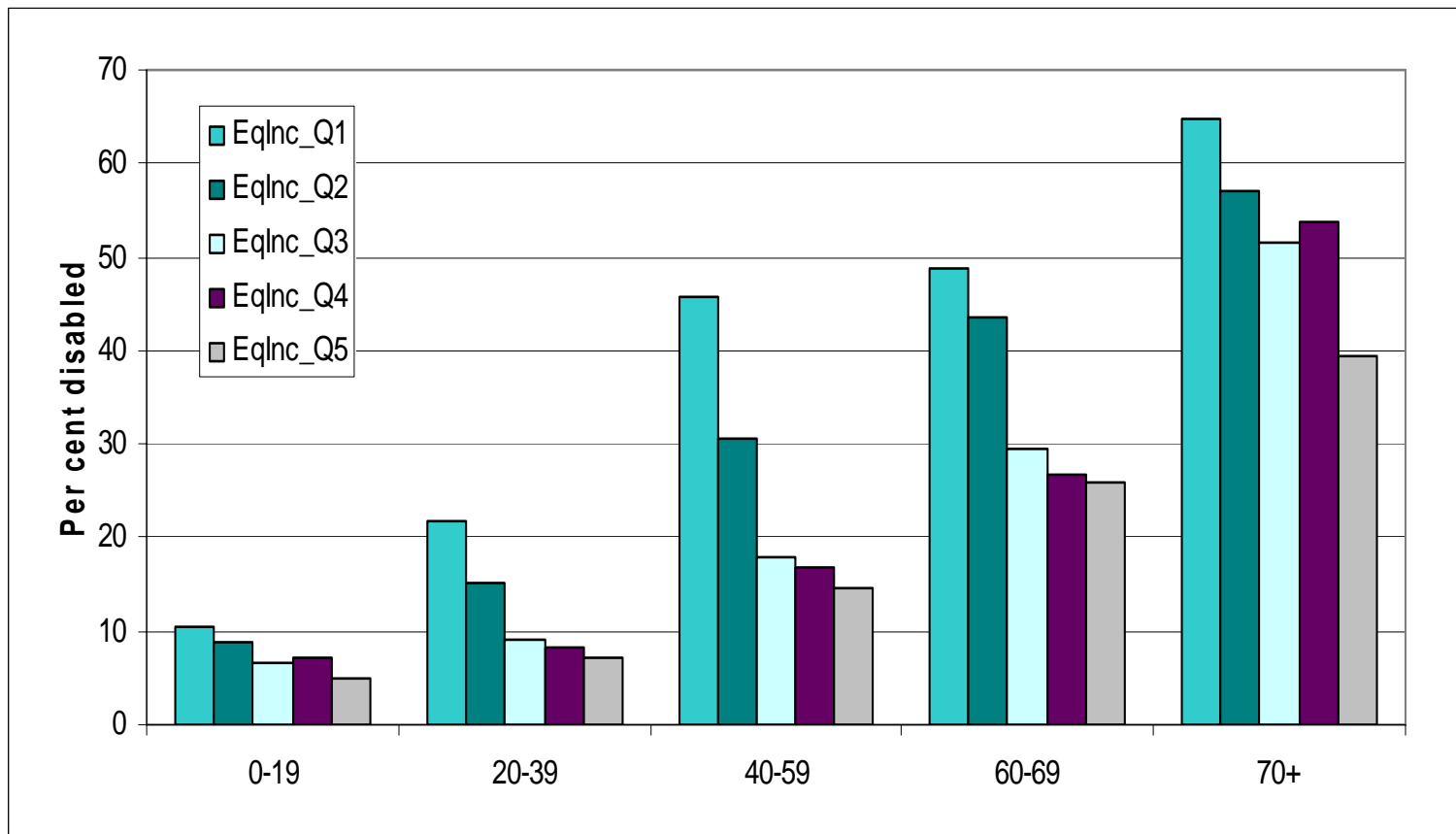


(1b) % disabled by age and SES, SEIFA

(Walker and Becker, Public Health – in press)



% disabled by age and SES, Eq_Fam_Incomecont'd (Walker and Becker, Public Health – in press)

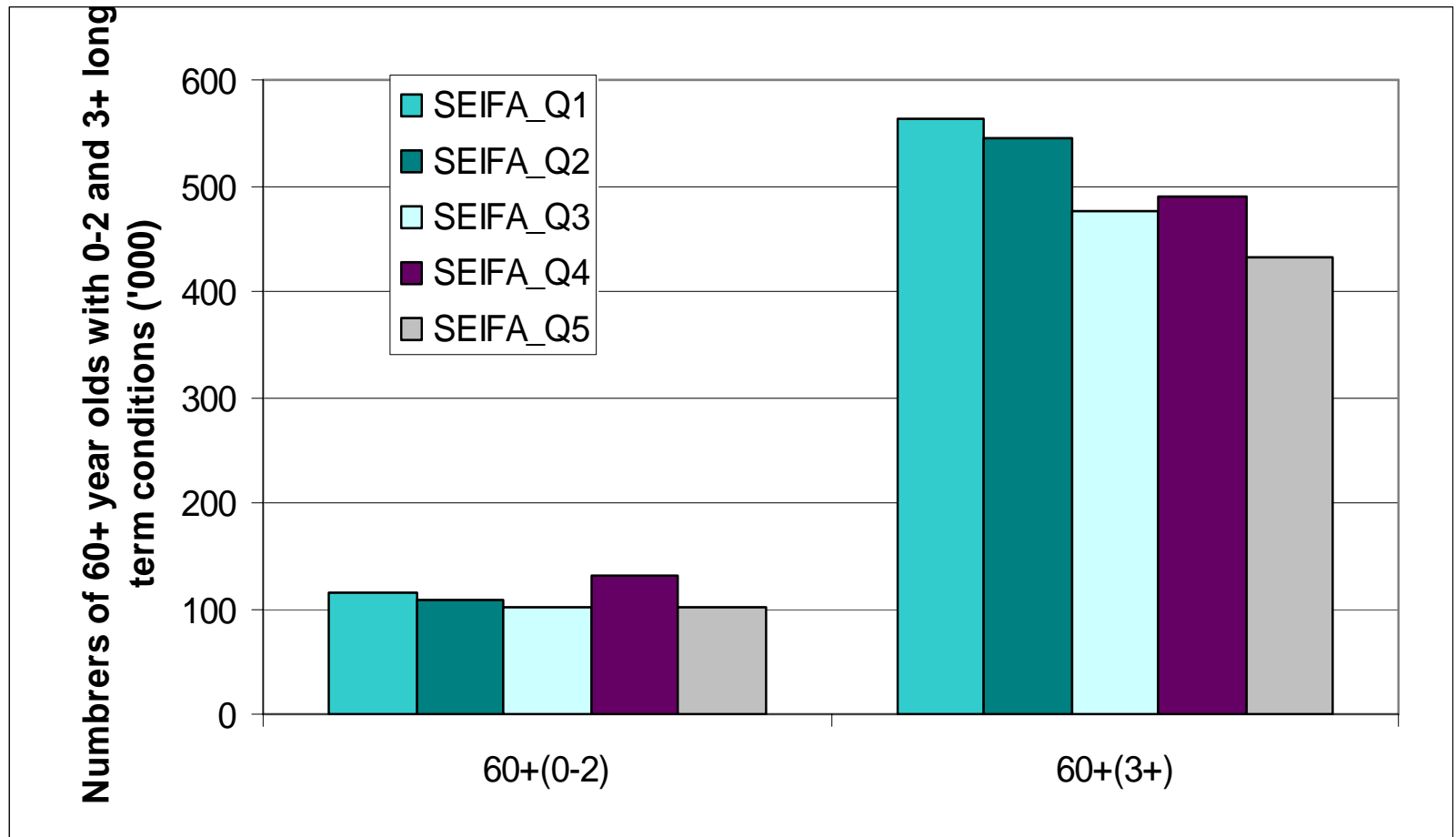




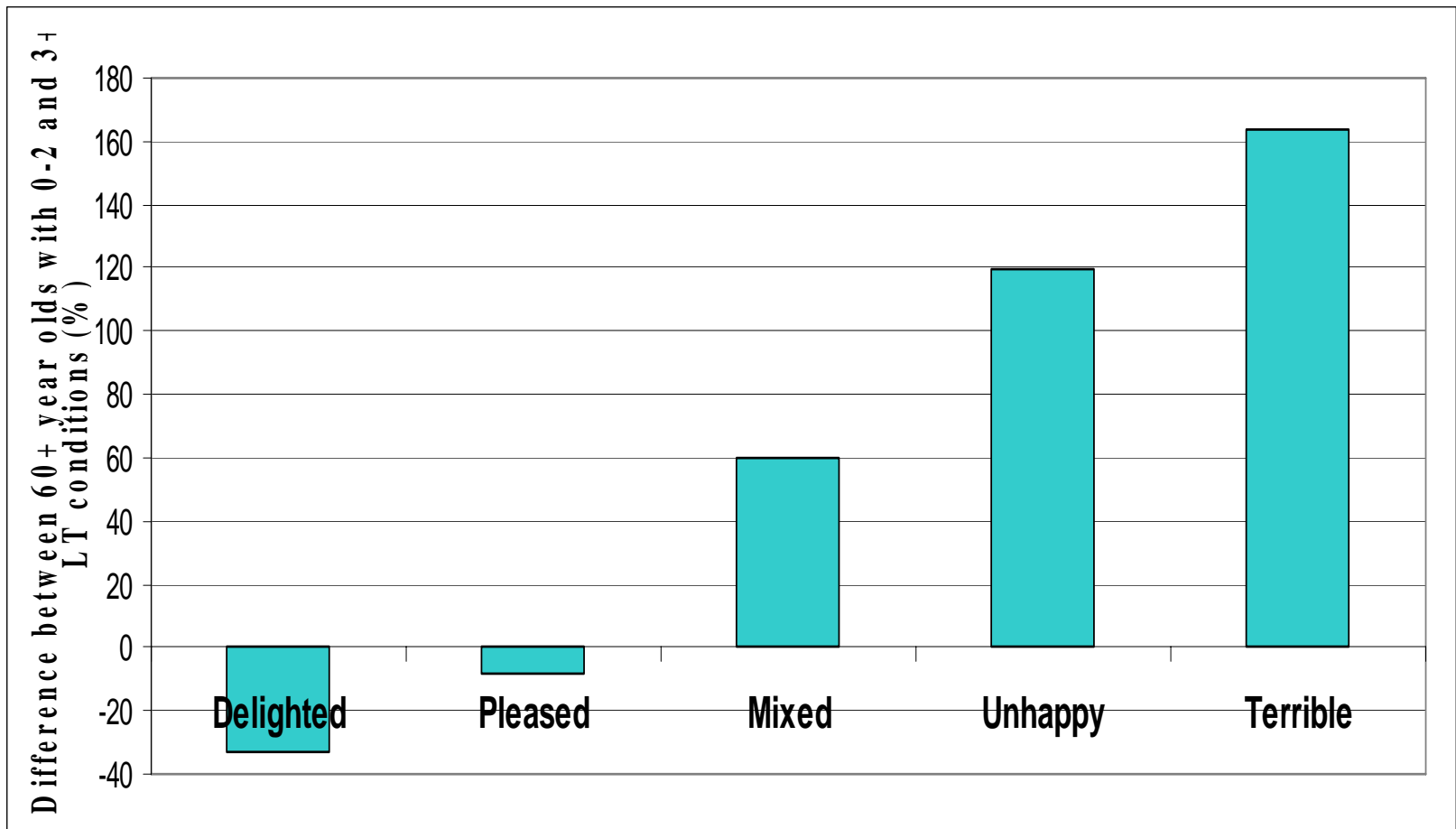
Are health differentials by socioeconomic status (SES) small?

(A2) Health differential can be large for some subgroups and small for others

(2b) No of long-term conditions by SES, 60+ year olds



(2c) Quality of life differences between 60+ year olds with 0-2 and 3+ LT conditions





B: which 'interventions' have been successful?

(B1) Overseas: examples

(B2) Australia: differential increases in PBS copayments

(B3) Australia: economic and health effects of narrower health inequalities

(B1) Overseas

- *US Perry Preschool Project*
 - by age 27, for every US\$1 spent on the Perry project, US\$7 were saved (lower expenditures on health, welfare, crime fighting, jail) - Tomison & Wise (1999)
- *Canadian Early Childhood project*
 - intervention aiming to narrow income inequalities (as well as their health consequences). Started in Ontario, extended to other Provinces
 - after 3 yrs, the project started to run into difficulties (benefits not clear, some sources of finance drying up, links with local communities too weak) - McCain and Mustard (1999 and 2002)
- *Developing countries*
 - project successfully changed health behaviours in Peru (combination of USAID, effective community involvement in four regions);
 - investing in education/training at local level led to:
 - improved water quality (India)
 - better sanitation (Lesotho)
 - health/maternity insurance for workers in low-wage informal sectors (West India) - Walker et al (2003) World Health Organisation report

(B3) Australia: benefits of narrower health inequalities

Were it possible to lift the health of all Australians to that of the richest 20 per cent, then

- *one million fewer Australians would be disabled*
- *over 180,000 life years would be saved*
- *health care costs would be A\$3 billion lower*
- *the government would save \$1 billion on the disability support pension (Walker 2004)*

C: concluding comments

Analysing the link between income inequality and health is fraught with difficulty

And so are policy responses implemented to date, with

- *the long time required for the benefits to emerge being a problem for politicians with short budget cycles*
- *project success depending on ability to involve potential beneficiaries over long periods of time*
- *planning (eg C/B analyses) and monitoring (eg tracking health benefits/savings) not well established in Australia*
 - *but improving*