Health inequalities have been found in all developed countries and for almost all diseases. Marked differences in health status occur between population groups as defined by gender, geography, ethnicity and socio-economic status. For example, affluent, privileged people have better health and lower mortality than poor, disadvantaged people (RACP, 1999).

The UK has been tracking the health gap between the rich and the poor for many decades, commencing formally in 1977 with a review chaired by Sir Douglas Black, known as the Black report (Black, 1980; Townsend et al., 1999). Twenty years on, the Blair government set up another expert committee to review progress in dealing with this issue chaired by Sir Donald Acheson (Acheson, 1998). They found that health inequalities had either stayed the same or had widened. Implicit in their review was the criticism that health promotion action had favoured the better off. The Acheson Committee recommended three crucial areas for action.

- All policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities.
- High priority should be given to the health of families with children.
- Further steps should be taken to reduce inequalities and improve living standards of poor households.

In Australia, the State Government of Victoria has used the Burden of Disease methodology to map the differences in health status between population groups, which are stratified by gender, rural location, socio-economic status, local government area and indigenous status (Vos et al., 1999). The measurements underpinning the analysis include: (i) life expectancy at birth; (ii) years of life lost due to premature death; and (iii) years lost due to disability or non-fatal health outcomes.

This work showed that male and female life expectancies since 1988 have consistently been 1 year greater in metropolitan areas than in rural and remote Victoria. More significantly, life expectancy has varied markedly across local government areas, with a difference of 7 years between the lowest and the highest male life expectancies over the period 1992–1996. For females the difference was 4 years. Socio-economic disadvantage is an important predictor of lower life expectancy, explaining one-third of the variation between areas. Overall, the male mortality burden in the lowest quintile of socio-economic status was 30% higher than in the highest, and in women this difference was 19%. Available information also suggests that life expectancy in Victorian Aboriginal men and women is between 8 and 18 years shorter than the state average.

Encouragingly, a repeat study for the period 1996–1999 shows that some health inequalities appear to be closing (Magnus, 2001). Against a background of improving life expectancy overall, the gap for males between the highest and lowest quintile of socio-economic status narrowed from 3.3 to 2.6 years between 1996 and 1999. For women the gap narrowed from 2.3 to 1.8 years.

The years of life lost (YLL) rates for this period showed similar trends. The gap between male YLL rates of the highest and lowest quintiles of socio-economic status was 25.2 per 1000 in 1996, but only 14.9 per 1000 in 1999. For females, the gap narrowed from 14.5 per 1000 to 10.6 per 1000. Reductions in cardiovascular disease and cancers mainly account for the changes.

One of the drivers for this welcome trend is likely to be smoking status. The Victorian Burden of Disease study shows that differences in lifestyle (for example smoking, nutrition, activity) explain about 30–50% of the variation. Through the activities of QUIT and other anti-smoking health groups, significant reductions have occurred in both male and female smoking rates in Victoria, from 38% male and 32% female in 1983 to 24% male and 18% female in 1999 (CBRC, 2001). These changes are attributable to a number of health promotion measures.
including visible and vigorous public campaigns, support for smokers to give up, progressive increases in the price of tobacco, and restrictions on marketing and provision of non-smoking work and eating places.

It is true that smoking initially declined in the more privileged and educated groups with a resulting increase in the difference between the smoking rates of socio-economic groups. But now there is increasing evidence that the most disadvantaged are also giving up in large numbers, with a narrowing of the gap. In 1987–1988, for example, 34% of employed people and 55% of unemployed people smoked in Victoria, a difference of 21%. By 1998–1999, smoking rates had fallen to 24% amongst the employed and 28% amongst the unemployed, a gap of only 4% (CBRC, 2001). Australia appears to be ahead of other countries in this area.

If these changes can be sustained, then this progress should encourage us to invest in further research, policies and services that will continue to improve the health of those most in need. At a political level, the Victorian Government has now highlighted reducing inequalities and disadvantage as one of the most important social development priority actions. Reducing health and social inequalities are built into the work programme of all divisions of the Victorian Department of Human Services (DHS, 2001).

Action is also being taken at a national level in Australia. A new resource to galvanize and support action is the Health Inequalities Research Collaboration (HIRC), established in 2000 by the Commonwealth Department of Health and Aged Care. The goal is to enhance Australia’s knowledge on the causes of and effective responses to health inequalities, and to promote vigorously the application of this evidence to reduce health inequalities in Australia (HIRC, 2001). Strategic objectives are:

- to increase the national focus on health inequalities,
- to build national capacity and support for research and development in health inequalities,
- to establish close collaboration among researchers, practitioners and policy developers, and
- to promote the uptake of research findings in policy, practice and evaluation.

An important component of HIRC’s work has been to set up three research networks: the Primary Health Care Research Network, the Sustainable Communities Research Network, and the Children, Youth and Families Research Network. These networks were chosen after consultation and consideration of the effectiveness of interventions. Rural and indigenous health will be important cross themes of all three networks.

Over the last 2 years, HIRC has focused on raising the issue of health inequalities with senior public servants and politicians. This effort has involved supporting visits from high-profile experts from overseas; for example, Professor Fraser Mustard from Canada and Professor Len Syme from the USA. Special events were held with Professor Michael Marmot from the UK, who spoke to the National Press Club and was broadcast live across Australia. Sir Donald Acheson also met with the HIRC Board and John Thwaites, the Victorian Minister of Health. Other visitors have included Professors David Hunter, Richard Wilkinson and Peter Townsend from the UK, and George Kaplan, Ichiro Kawachi and Robert Putnam from the USA.

HIRC has organized a national conference and commissioned papers and expert reviews. New alliances have been formed with other areas with momentum, e.g. National Initiative for the Early Years (NIFTEY). Health inequalities are also becoming a focus of national research funding and health priorities planning through the National Health and Medical Research Council, and the National Health Priorities Action Council. Most strategically, the influential multidisciplinary HIRC Board now reports to both Health Ministers and Community Services Ministers on intersectoral opportunities.

As part of its work, HIRC commissioned a review of evidence-based actions to reduce health inequalities (QUT, 1999; Oldenberg, 2000). The authors concluded that strategies should focus on macroeconomic and social policies, living and working conditions, behavioural risk factors and the health care system. The key findings are summarized below.

Evidence-based actions to reduce health inequalities are as follows.

1. Macroeconomic social policies
   - Pursue policies that build up the national health capital through investment in physical assets (i.e. health care system infrastructure, schools, transport systems, housing) and social assets (i.e. education, social security, participation in civil society).
• Reduce income differentials and poverty through progressive taxation and the provision of adequate income support for those in poverty (especially families with young children).
• Reduce unemployment through labour market policies that strengthen the position of those at greatest risk of unemployment (e.g. young people and those living in disadvantaged communities).

2. Living and working conditions
• Implement community development programmes in disadvantaged areas that focus on creating supportive community networks, with funding to invest in schools, day care centres, recreation and leisure facilities and health services.
• Implement workplace reforms that enable employees to have greater control and influence over their work and conditions.

3. Behavioural risk factors
• Implement behavioural change strategies among disadvantaged groups, with an understanding of and sensitivity to the barriers to change that difficult life circumstances can impose.
• Implement behavioural health promotion among disadvantaged groups that is complemented with support and structural change to facilitate the change process.

4. The health care system
• Maintain a universal non-targeted health care system.
• Provide a health care system that is publicly funded through taxation.
• Provide an economically, geographically and culturally accessible health care system.
• Redistribute resources within the health care system to support public health and health promotion programmes, including primary and community care programmes.
• Focus health care reform on the providers of care and the funding allocation mechanisms that distribute funds to service providers.
• Implement health care reform and intersectoral collaboration as complementary strategies.

In the past we may have thought pessimistically that efforts to reduce health inequalities were in the ‘too hard basket’; that progress, although warranted, was near impossible given pervading social and economic contexts. However, the emerging evidence that health inequalities can indeed be reduced over the period of a decade should encourage renewed investments in research, policy and services that close the ‘gap’ more effectively. Health promotion has much to offer in formulating both the questions and the answers.

The lesson from these developments indicates that all countries should consider a nationally coordinated and strategic approach to tackle health inequalities, because the socioeconomic determinants of health are both complex and pervasive. This needs to go well beyond the responsibilities of health services as other government departments control the crucial policy levers. These include macroeconomic policy; the tax/income transfer system; labour market programmes; occupational and industrial relations; child care; health financing and budgeting; the universal and targeted service systems; and the environment for employment, business growth and productivity. Progress clearly requires leadership and political cooperation at all levels of government.

Health promotion professionals should feel optimistic that they can play a part by advocating ‘upstream’ strategies, including greater investment in research and policy development. In addition, they should continue to address the health needs of the most disadvantaged through their day-to-day service and practice. Progress can occur in reducing health inequalities.

John Catford
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