SOCIAL DETERMINANTS OF HEALTH ALLIANCE

Social Determinants of Health Alliance *submission to the Senate Standing Committees on Community Affairs on the Extent of income inequality in Australia*

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Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Email: community.affairs.sen@aph.gov.au

Contact for SDOHA:
Michael Moore
Chair of SDOHA
C/- Public Health Association of Australia
PO Box 319
Curtin ACT 2605
Email: accounts@phaa.net.au

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Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries (WHO, 2008).

The Social Determinants of Health Alliance

The Social Determinants of Health Alliance (SDOHA) is a group of like-minded organisations established to advocate to governments at all levels and, to lead coordinated action across sectors on the determinants of health in order to reduce health inequities (a) in Australia. Abundant evidence shows that the higher your income or level of education in Australia, the better your health will tend to be. People in the most disadvantaged social groups are also far more likely than those in the higher socioeconomic groups to have long-term physical or mental health problems. Thus, they may be less able to complete an education or maintain a job to retirement, and are more likely to die at a younger ages.

For many years, and particularly the last decade, a number of Australian organisations, academics and public policy leaders have become increasingly interested in improving Australians' well-being and reducing health inequities by addressing the social factors – or "determinants" – that strongly influence people's health. The Social Determinants of Health Alliance was formed in October 2012 with the goal of working with governments to improve health outcomes for all Australians, and especially among those who are subject to social or economic disadvantage. The Alliance membership includes some of the Australia's leading health equity researchers as well as leading health promotion and social service organisations.

Preamble

SDOHA welcomes the opportunity to provide input to the Senate Standing Committees on Community Affairs (the Committee) current inquiry on the extent of income inequality in Australia.

The recent Parliamentary Inquiry and recommendations in relation to *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation"* (Community Affairs References Committee, 2013) is a step in the right direction for progressing the Social Determinants of Health agenda in Australia. However we would like to remind Senators that the Committees' report made recommendations in the March 2013 response that, if implemented, have the capacity to progress equity and provide architecture for government coordination of equity outcomes.

The five recommendations of that Inquiry, that involve Parliamentary ratification of the WHO plan, a coordinating process across government to consider health in all policies, annual reporting on social determinants to the Parliament, and priority within National Health and Medical Research Council grants for

social determinant research, are not controversial and not expensive. Implementing the recommendations of the Inquiry would certainly be a good place to start in terms of addressing inequality in Australia.

At the recent *Social Determinants of Health Research Forum* in Canberra, Dr Gemma Carey and Mr Bradley Crammond launched their report *Taking Action on the Social Determinants of Health: Insights from politicians, policymakers and lobbyists*, drawing attention to the fact that "Despite the best efforts of the involved Parliamentarians and non-government advocates, and a fledgling alliance of national health and social service organisations wanting to built momentum to see the Inquiry's recommendations implemented, there has been little to no action since March 2013 to give effect to the decision of the two main political parties who at all times since Federation have either served as our elected Government or primary Opposition" (Carey & Crammond, 2014, p4).

For the purpose of this report, SDOHA has focused on the socioeconomic characteristics of determinants such as education, employment, income and wealth, family and neighbourhood, housing, access to services, migration/refugee status and how the Committee can impact these needs within the community. This submission provides further arguments to advance the five recommendations given by the Committee and support for the Committees Terms of Reference and urges the Committee to agree to once again seek to implement the tri-partisan supported recommendations of the Inquiry.

World Health Organisation recommendations for Closing the Gap in a Generation

1. ***Improve Daily Living Conditions*** *– Improve the well-being of girls and women and the circumstances in which their children are born, put major emphasis on early child development and education for girls and boys, improve living and working conditions and create social protection policy supportive of all, and create conditions for a flourishing older life. Policies to achieve these goals will involve civil society, governments, and global institutions.*
2. ***Tackle the Inequitable Distribution of Power, Money, and Resources*** *– In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities – such as those between men and women – in the way society is organised. This requires a strong public sector that is committed, capable, and adequately financed. To achieve that requires more than strengthened government – it requires strengthened governance: legitimacy, space and support for civil society, for an accountable private sector, and for people across society to agree public interest and reinvest in the value of collective action. In a globalized world, the need for governance dedicated to equity applies equally from the community level to global institutions.*
3. ***Measure and Understand the Problem and Assess the Impact of Action*** *– Acknowledging that there is a problem, and ensuring that health inequity is measured – within countries and globally – is a vital platform for action. National governments and international organisations, supported by WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health and should evaluate the health equity impact of policy and action. Creating the organisational space and capacity to act effectively on health inequity requires investment in training of policy-makers and health practitioners and public understanding of social determinants of health. It also requires a stronger focus on social determinants in public health research.* (WHO, 2008)

SDOHA Responses to Committee Terms of Reference

At a recent SDOHA forum in Canberra, speakers presented the latest research findings and evidence in relation to factors impacting on the health of Australians and efforts to improve the nation's health. This evidence demonstrates the vital need for Commonwealth, State and Territory governments to work together if Australia is to address the social determinants of health and achieve better health outcomes for the Australian community

a) The extent of income inequality in Australia and the rate at which income inequality is increasing in our community;

Income inequality in Australia has been rising since the mid 1990s (Treasury.gov.au, 2014) with the Australian Institute of Health and Welfare (AIHW) reporting the mean (average) equivalised income in 2009-10 (after tax) of households with the lowest incomes was $314 per week, compared with $1,704 per week for households with the highest incomes (AIHW, 2013).

Australia21 in conjunction with the Australian National University (ANU) and the Australia Institute also released a report in January 2014 *Advance Australia Fair? What to do about growing inequality in Australia* identifying contributing factors to rising income inequality in Australia. These factors include tax cuts and tax exemptions that favour the rich, globalisation, asymmetric access to rapid technology change, changes in compensation practices for top executives, and 'rent seeking' – the practice of wealthy organisations, companies or individuals using their resources to obtain economic gain at the expense of others, without contributing to productivity (Douglas et al., 2014).

b) The impact of income inequality on access to health, housing, education and work in Australia, and on the quality of the outcomes achieved;

The accumulated evidence on social determinants of health clearly demonstrates that income is a fundamental determinant of health and that income inequality can contribute to poor health in a variety of ways. Firstly, low socioeconomic status determined by income will frequently give rise to exposure to a variety of stressors such as insecure housing and difficulties with managing household finances. Stress gives rise to changes in both the brain and body which can be adaptive in the short term, but if sustained over longer periods contributes to common forms of mental illness such as depression, and increased risk of conditions such as heart disease. Low income is also likely to be associated with other well recognised stressors such as insecure employment and unsafe neighbourhoods (Fisher & Baum, 2010; Thoits, 2010).

Secondly, income inequality is a key determinant of where people live, and in Australia's major cities having a low income is likely to mean that the housing you are able to afford will be either in inner urban areas of concentrated disadvantage, or suburbs on the outer periphery of a metropolitan area. In the latter case in particular this may mean relatively poor access to services such as public transport and health care, and limited access to employment opportunities. In either case it may mean living in lower quality housing. Higher transport or utility costs may also compound economic disadvantage. All of these are factors recognised in evidence as likely to adversely impact on health (Cruwys,2013).

Thirdly, income inequalities significantly affect the choices people make, or are able to make, in relation to matters such as access to health care and food consumption. Low income as a barrier to primary health care means that people are less likely to benefit from preventive interventions and more likely to end up with chronic conditions requiring more expensive and longer-term care. Low income as a barrier to healthy food choices contributes to obesity (AIHW, 2014).

Fourthly, given the growing inequities emerging in Australia's education system (Gonski et al. 2011), low income means you are more likely to attend a public school which is disadvantaged both in terms of resources and in the concentration of socioeconomically disadvantaged students attending which for many this will be a barrier to educational achievement. This is one way in which low parental income can increase the prospects of low income for their children.

Fifthly, there is significant evidence available suggesting that the degree of income inequality matters for health across all levels of society (Wilkinson & Pickett 2009). In comparisons of high-income economies similar to Australia those with higher levels of income inequality consistently show worse outcomes on a variety of measures of social wellbeing including mental health, levels of trust and crime rates, across all levels of socioeconomic status (Friel et al, 2008).

As outlined in the two reports from Catholic Health Australia and the National Centre for Social and Economic Modelling, there are billions in savings that could be made in Australia's health system through improving the social determinants of health (NATSEM, 2010 and 2012).

The findings of *The Cost of Inaction on the Social Determinants of Health* suggest that if the World Health Organization's recommendations were adopted within Australia:

- 500,000 Australians could avoid suffering a chronic illness;
- 170,000 extra Australians could enter the workforce, generating $8 billion in extra earnings;
- Annual savings of $4 billion in welfare support payments could be made;
- 60,000 fewer people would need to be admitted to hospital annually, resulting in savings of $2.3 billion in hospital expenditure;
- 5.5 million fewer Medicare services would be needed each year, resulting in annual savings of $273 million;
- 5.3 million fewer Pharmaceutical Benefit Scheme scripts would be filled each year, resulting in annual savings of $184.5 million each year (NATSEM, 2012)

AIHW also reports that in general, the higher people's incomes and education, the healthier they are. This follows that the better off people are, the more they are able to afford better food and housing, better health care, and healthy activities and pursuits and are more likely to be better informed about healthy choices and behaviours (AIHW, 2014 p25).

c) The specific impacts of inequality on disadvantaged groups within the community, including Aboriginal and Torres Strait Islander peoples, older job seekers, people living with a disability or mental illness, refugees, single parents, those on a low income, people at risk of poverty in retirement as well as the relationship between gender and inequality;

Aboriginal and Torres Strait Islander peoples

The recent publication *Australia's Health 2014* released by AIHW reports that Indigenous Australians are generally less healthy than other Australians and more likely to die at younger ages (AIHW, 2014 p24). The health gap between Indigenous and non-indigenous populations within Australia is particularly obvious when considering the difference in life expectancy between Indigenous and non-Indigenous Australians. Life expectancy is still 10.6 years lower for Indigenous males and 9.5 years lower for Indigenous females than non-Indigenous Australians (AIHW, 2014).

Indigenous Australians have a burden of disease 2-3 times greater than the general Australian population and are more likely to die at younger ages, experience disability and report their health as fair or poor and are disproportionally represented in remote and very remote areas of Australia making up 45% of the very remote and 16% of the remote populations (AIHW, 2014).

In addition to the disadvantages noted above, Indigenous Australians continue to have lower levels of education compared to non-Indigenous Australians with 26% of Indigenous Australians aged 15 years and over having completed a non-school qualification compared to 49% of non-Indigenous Australians and only around 3% completing a Bachelor degree compared with 14% on non-Indigenous Australians (AIHW, 2014).

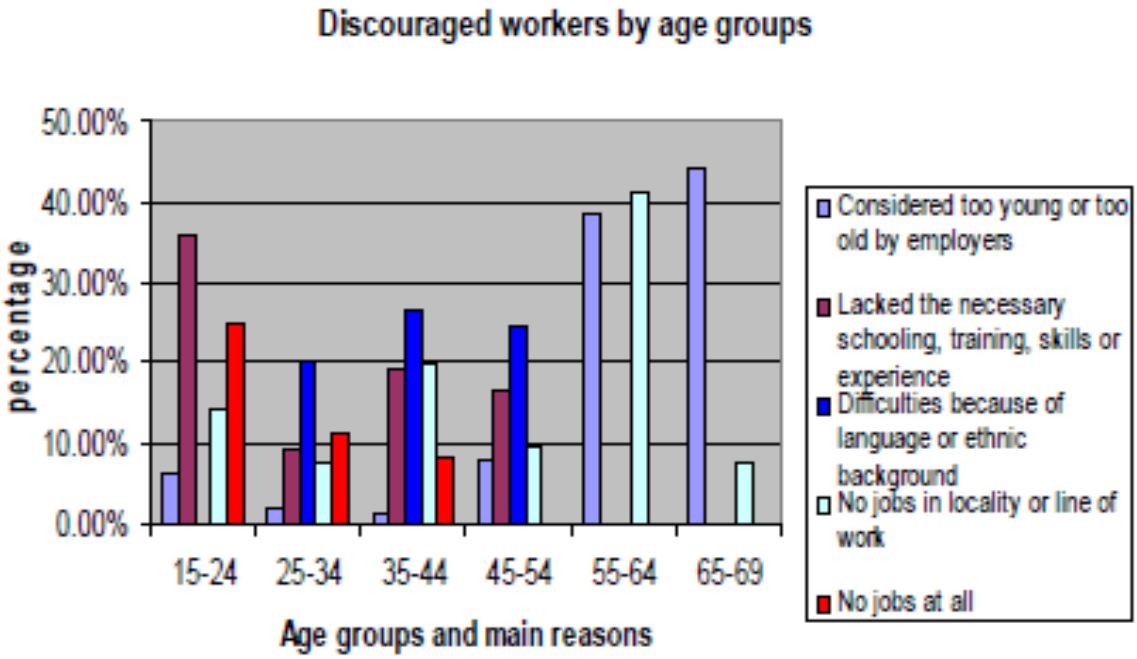
There is a clear relationship between the social disadvantages experienced by Indigenous people and their current health status (Carson et al. 2007). These social disadvantages, directly related to dispossession and characterised by poverty and powerlessness, are reflected in measures of education, employment, income, housing, access to services, social networks, connection with land, racism, and incarceration. On all these measures, Indigenous people suffer substantial disadvantage.

Older job seekers

Figures released in *Australia's Health 2014* show that Australia's population is ageing with the number of people aged 65 years and over tripling from 1.1 million to 3.3 million from 1973 to 2013. This means that older Australians now comprise 14% of the population and are increasingly working past the age of 65 with a 15% rise in the labour force participation rate for men and a 14% rise for women between 2002 -2012 (AIHW, 2014).

However, figures from the Australian Bureau of Statistics show that workers over the age of 45 frequently experience difficulties in gaining employment due to age discrimination. This can lead to long term unemployment, consequent disadvantage and mental health impacts for mature age workers (Brooke, 2008).

Figure 1: Difficulties in finding work by age (ABS, 2007)



People living with a disability or mental illness

The National Mental Health Report 2013 recognises that "the determinants of mental health status comprise a range of psychosocial and environmental factors (including, for example, income, employment, education and access to community resources), and encompasses the entire spectrum of interventions from mental health promotion through to recovery." It highlights the need for a range of service coordination to reduce the severity of mental illness including services designed to alleviate the disablement that may be associated with a person's social, personal and vocational functioning (National Mental Health Report, 2013).

There is further evidence to suggest that mental disorders may have far-reaching effects on society as a whole and are commonly associated with economic disadvantage, unemployment or under-employment, homelessness and reduced productivity (AIHW, 2014).

Lesbian, Gay, Bisexual, Transgender and Intersex (LBGTI) People

Evidence shows that the poorer health outcomes that LGBTI people have are largely due to the discrimination and social isolation that they face, which lead to higher rates of drug use, mental health issues and other risky behaviours and creates barriers for LGBTI people accessing mainstream health services (Lgbtihealth.org.au, 2014).

In Australia, one study of Melbourne's homeless young people found that 16% identified as lesbian, bisexual, or gay (Rossiter, Mallett, Myers, & Rosenthal, 2003). Another Australian study found that 30% of all homeless young people identified as lesbian or gay (Irwin, Twenty-Ten [N.S.W.], & Australian Centre for Lesbian and Gay Research, 1995). Transgender young people are also more likely to become homeless than the general population (Ray, 2006). Shelter policies that classify young people according to their assigned sex at birth contribute to discrimination against trans/transgender and intersex young people even in LGB-welcoming settings (Ray, 2006).

Refugees

Those of refugee background may face barriers to accessing health care due to issues such as language, culture, transport and cost and from policy decisions such as lack of access to Medicare for asylum seekers (Milosevic et al. 2012). Prolonged immigration detention is also having significant detrimental impact on the mental health of asylum seekers, the effects of which are reported to continue post-release even after gaining permanent residency (Coffey et al. 2010).

Single parents/ Low income earners/ People at risk of poverty in retirement

Figures from the Australian Bureau of Statistics (ABS) show that out of the 1.3 million jobless families, 299,000 of these were single parent families – almost 1 in every 3 single parent family in Australia. Of all families with children, 26% were one-parent families (AIHW, 2014). And while people earning the lowest incomes in Australia are likely to have poor health those living in rural and remote areas also tend to have higher risk of disease factors than people living in major cities (AIHW, 2014).

The University of Canberra identified 'Five Domains of Disadvantage' outlined in the following table which highlight the interconnectedness of the disadvantaged groups, social determinants of health and their relation to inequality in Australia.

Table 1: Marginalisation – Five Domains of Disadvantage (Cruwys et al. 2013)

Domain	Indicators
A. Social Stigmatisation	Membership of multiple highly stigmatised groups (e.g., being of Indigenous origin, being a welfare-reliant single parent, having a disability, not having paid employment)
B. Early-life disadvantage	Parental divorce, parental unemployment, incomplete schooling, early departure from childhood home
C. Financial Hardship	Reliance on government income support, little or no wealth, unfavourable forms of debt, low income, high financial stress
D. Poor Health	Chronic health problems, poor physical functioning, poor mental health, adverse health behaviours
E. Social Isolation	Few social contacts, little social support, poor quality relationships

d) The likely impact of Government policies on current and future rates of inequality particularly the changes proposed in the 2014-15 Budget;

SDOHA wishes to raise the following as concerns as issues of inequity in the 2014-15 budget and the cumulative effect of the multiple measures on the poorest Australians:

- Introduction of a GP co-payment for GP, pathology and diagnostic imaging services
- Increase in co-payments for PBS listed medicines and changes to safety net thresholds
- Reduction in federal funding to public hospital sector due to change to CPI indexation in funding formula
- Cessation of the National Partnership Agreement on Preventive Health, and other reductions in funding for preventive health measures
- Reductions in funding to Aboriginal and Torres Strait Islander Health measures
- The reduction in eligibility thresholds for the Child Dental Benefits Schedule

- Cessation of the Dental Flexible Grants Program
- Deferral of the National Partnership Agreement for adult public dental services
- Pausing indexation of MBS fees, Medicare Levy Surcharge and Private Health Insurance Rebate thresholds
- Reduced funding for the Partners in Recovery mental health program
- The 6 month qualification period for the unemployment benefits for people under 30
- Reinstitution of fuel excise tax which will have a regressive impact for low income Australians
- Moving away from the Gonski recommendation of needs based funding for primary and secondary education
- Decreased funding of higher education increasing user pays and reducing access for the least wealthy
- Income benefit indexation
- Reduced Commonwealth financial contribution to States for funding of public health and education services

e) The principles that should underpin the provision of social security payments in Australia;

Social security payments should enable those receiving them (at the least) to maintain the basic and essential material elements of life which enable social participation and protect health, including secure housing, utilities, clothing, food security, and access to primary health care and education.

The social security system should provide clear, achievable pathways into meaningful education and training and employment opportunities, with a particular focus on tackling long-term unemployment. Using poverty as a penalty to 'motivate' participation in the employment market is ethically unjustifiable, ineffective and likely to be counter-productive (Cruwys, 2013).

f) The practical measures that could be implemented by Governments to address inequality, particularly appropriate and adequate income support payments.

A range of coordinated and accountable actions are required in areas of education, employment, early childhood, the built environment, economic policy and social inclusion in order to achieve sustainable development and increased productivity into the future.

SDOHA supports the five recommendations of the Senate Standing Committee on Community Affairs' 20 March 2013 Inquiry report on *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report 'Closing the gap within a generation'*:

Recommendation 1

4.45 The committee recommends that the Government adopt the WHO Report and commit to addressing the social determinants of health relevant to the Australian Context.

Recommendation 2

4.63 The committee recommends that the government adopt administrative practices that ensure consideration of the social determinants of health in all relevant policy development activities, particularly in relation to education, employment, housing, family and social security policy.

Recommendation 3

4.71 The committee recommends that the government place responsibility for addressing social determinants of health within one agency, with a mandate to address issues across portfolios.

Recommendation 4

5.36 The committee recommends that the NHMRC give greater emphasis in its grant allocation priorities to research on public health and social determinates research.

Recommendation 5

5.38 The committee recommends that annual progress reports to parliament be a key requirement of the body tasked with responsibility for addressing the social determinants of health.

SDOHA Recommendations

As per the SDOHA report *Everything but 'health'* submitted to the Committee in March 2013, the Social Determinants of Health Alliance calls for:

1. Adoption of the WHO framework contained in the Commission on Social Determinants of Health report Closing the Gap in a Generation. This adoption would embed the paradigm change and commitment to addressing the social determinants of health.
2. Leadership from the Department of Prime Minister and Cabinet to implement a coordinated whole-of-government approach to social determinants of health and health inequities.
3. Federal Government encouragement for COAG to adopt the WHO framework, and a COAG-led discussion with states and territories to examine the impact of the social determinants of health through their administration of state-based policies and programs, for example within the justice system, housing, utilities and community-based services.
4. Delivery of an annual report to Parliament by the Prime Minister on the social determinants of health that aims to monitor the distribution of health inequities in order to feed back into policy development.
5. Implementation of mechanisms to routinely assess the impacts of policies on health and equity across all sectors of government: options may include application of health impact assessments (the potential effects on population health from procedures, methods and tools used in policies, programs or projects) or a "health in all policies" approach similar to that used in South Australia (commencing prior to a policy or proposal being developed).
6. An equity audit of existing health and social programs – conducted as a starting point to support the development of a national strategy. The audit should include information on accessibility and use of programs as well as duplication.
7. Development of a national strategy to address health inequity by actions to reduce social inequities in income distribution, educational achievements, labour market, working environments, health behaviours and health services.

8. Continued action in partnership with Indigenous communities and leaders to advance the social, economic and cultural development of Aboriginal and Torres Strait Islander peoples through action on social determinants of health – including in the justice system and policing.
9. Building on the social inclusion agenda to address social determinants of health affecting disadvantaged groups and areas of concentrated disadvantage. Efforts to increase social inclusion should recognise and address the diverse and population-specific needs and determinants of the distinct groups that collectively constitute population blocs more broadly described as Aboriginal and Torres Strait Islander peoples, Culturally and Linguistically Diverse populations, LGBTI populations, older job seekers, people living with a disability or mental illness, refugees, single parents, those on a low income, and people at risk of poverty in retirement.
10. A Productivity Commission assessment of the cost of health inequity and the benefits of adopting a Social Determinants of Health approach.
11. A specific focus on understanding and evaluating effective interventions to address social determinants of health and health inequalities within ARC and NHMRC research agendas.

In calling on the Government to adopt these measures, the Social Determinants of Health Alliance seeks a fairer and more equitable future for all Australians. While this is an important social goal in itself, there are also important economic and other broader welfare benefits that can be associated with this outcome.

Whole-of-Government approaches are often called for and the needs of disadvantaged groups within Australian society are well known. The opportunities presented here would produce meaningful changes for the benefit of all Australians.

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(a)The term “health inequities” has been used in this report in preference to the more frequently used term “health inequalities”, as it more aptly describes avoidable and unjust health differences (Whitehead, 1990).