

Impoverished Poverty Policy and the Implications for Health

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Abstract

This paper argues that any effort to diminish health inequalities that lacks a commitment to reduce poverty is going to be ineffective. The bio-medical model has dominated the policy agenda, and a liberalist framework has supported the agency argument of lifestyle determinants of health status. While there has been recent research in the area of social, economic and environmental causes of health inequality, this has had little impact on the delivery of health services. This may be due to the lack of clarity in the requirements for structural change using social determinants of health as a conceptual policy framework. Recent concepts of social capital and social exclusion have overtaken the use of the terms ‘under-class’ poverty, anomie and alienation in the policy arena. An ideological and structural analysis of poverty and health policy is undertaken, with a particular focus on how the definition of poverty influences the types of policy responses and determines policy priorities.

Introduction

The catalyst for this paper was the dilemma raised by a former health senior public servant in Tasmania after a study was conducted into the health needs of a small regional city. In the study, it was identified that there were high levels of unemployment for men aged over forty-years, and a consequential increased reliance on health services in the area, which were already over-stretched. This raised a number of questions for the development of health policy.

Should any additional effort focus on increasing the health services, or on employment or training courses, or both? If additional resources were to be applied, from what source should the cost shift? From a more affluent community, the major hospital in the region, or the local government through increased rates or taxes. (Boyer, 2000, 31)

This paper argues that any effort to diminish health inequalities that does not address the reduction of poverty is going to be ineffective. It examines the links between health inequality and poverty policy, with a particular focus on how the definition of poverty can influence the type of policy responses and policy priorities. In Australia, as in most OECD countries, the concepts of social capital and social exclusion are being used in the definition of poverty and the development of policy responses. While governments continue to endorse policies that encourage the dominance of the market under a neo-liberalist paradigm, they also argue for equity in health for all Australians. Although Australia has been described as a nation that pursues egalitarian ideals, health policy responses have, until recently, focused on strategies to enhance the equity of access rather than outcome. In the last decade, there has been a move to measure outcomes for

clients receiving public services such as health. While this has influenced funding models (the input end), it has not resulted in greater equity of outcomes such as health status.

The policy responses to health inequality are examined using a conceptual, ideological and structural analysis of the health system in Australia and international directions for health policy.

Defining health

A key stage in the policy process is the definition of the problem. While in a rational policy process this can often lead to the definition influencing policy responses, in some policy areas, such as health, the complexity of the problem and difficulties with measurement can lead to the absence of effective policy initiatives. In Australia, the 1946 World Health Organisation (WHO) definition of health is generally used in policy documents: “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organisation, 1946, cited in Australian Institute of Health and Welfare, 2002, p. 3). This definition provides three over-arching conceptual frameworks for the way the nature of the problem is defined. First, this definition implies that health is related to well-being (social and economic). It affects how people feel and their ability to function. Secondly, it concerns not just the absence of illness and disease, but rather the degree of wellness. The final conceptual component of this definition is that, if well-being on the three levels is to be achieved, then health needs should be understood in a broad social context, which are defined in the health policy area as “social determinants of health” (Australian Institute of Health and Welfare, 2002, p. 3). However, the measurement of health within these criteria has proven to be difficult.

Wellbeing, health and fitness are all subjective concepts that can be interpreted in various ways by different people. Further, since sick people come into contact with health care services more often than do healthy people, health is often measured in an indirect manner. Much of this measurement has focused on the negative aspects of health - illness, disease, disability and death. (de Looper and Bhatia, 2001, p. 3)

In Australia, policy initiatives have been the result of an agency view of lifestyle, and a bio-medical structure and ideology that has limited the development of policies that focus on the social context and the notion of well-being. Policy documents from the late 1990s focus on identifying specific illnesses for policy initiatives, which largely replaced a focus on identified disadvantaged groups. Disadvantaged groups have been traditionally defined by disability, gender, age and ethnicity, and not characteristics of social or economic disadvantage. This has been the case despite the fact that key studies in Australia, and internationally, have found direct correlations between health and social and economic determinants.

The 1992 Australian National Health Strategy Report found that socio-economic factors are clearly associated with health, and that structural changes outside the health care system are needed. This study found that people with a lower socio-economic status had higher mortality rates for pneumonia, influenza, lung cancer, bronchitis, emphysema, asthma, diabetes and suicide. In 1994, the Commonwealth Department of Human Services and Health outlined, in the publication *Better Health Outcomes for Australians*, the relationship between socio-economic status and health:

Whether measured by income, educational level, occupation or areas of socio-economic disadvantage, there is a consistent relationship between socio-economic status and

health... National effort to address these differentials in health status must be increased despite the complexity of the task. (p. 13)

In policy documents in the early to mid 1990s, there has been reference to socio-economic status and health, but as the relationship was few policy initiatives developed. Initiatives that were implemented were community based and often short-term pilot projects. The role of social determinants in relation to health has not been included in Commonwealth Health reports and policy documents from the late 1990s onwards. Current policy development in health has seen a shift of responsibility from the state to the individual. The focus now is on lifestyle and behaviour in a private sector setting within the framework of a medical model.

Structural changes

Hancock (1999, p. 3) identifies structural changes that have impacted on the delivery of health services in Australia, and which have been instrumental in the low priority given to policy initiatives aimed at reducing health inequality. One of the central structural changes has been the increasing dominance of market values and economic efficiency in policy development. In health delivery, this dominance is seen to be at the expense of other values, such as access (which has resulted in the closure of regional services), less focus on policies of social equity (gender, ethnicity, age and disability groups replaced by medical-driven priority areas), a reduction in the quality of care, and a reduced ability to cater for the diversity of needs. Longer-term sustainability has been replaced by short-termism where costs, risks and benefits are assessed in the immediate future. The new managerialist approach, introduced in the early 1980s as part of these structural reforms, focus on cost savings, output measures and usually quantitative techniques that have led to a loss of programme and service integrity, reduction in the quality and time to care, and reducing democratic participation in a decreasingly less open and accountable system.

The Australian policy area has experienced a move to the individualisation of risk and responsibility, which has resulted in policy initiatives that focus on the agency view dominating the agenda. This change has led to a shift from a redistributive model based on a taxation funded, universal health system to one based on the individual's ability to pay. In this case, the recognition of the causal relationships of poverty, unemployment and disadvantage on health are replaced by a notion of individual responsibility and lifestyle, with safety net services for the economically disadvantaged. This has resulted in the development of a two-tiered system of health. Those with private insurance are able to access preventative services and alternative treatments, while these are not covered under the public system. This means that those reliant on the public health system do not have access to preventative and alternative treatments which are often founded on principles of the social determinants of health.

Shifts to risk management and accountability through contractualism and privatisation have led to narrow budget accountability. This can be seen as a move from broad public interest accountability to quantitative budget accountability. This can be seen as blurring and transforming the accountability of government to clients. Broad banded funding has been justified through the process of devolution to improve increased flexibility. This can threaten the policy development of smaller programmes and the ability to cater for disadvantaged and diverse needs, as well as monitoring delivery and outcomes. Australia's health budget is largely directed towards bio-medical concerns, such as GPs, specialist consultations, radiology, surgical procedures, pharmaceuticals, diagnostic pathology and public hospitals. Preventative treatments are largely not funded through the public system, so those with higher disposable incomes have greater access to preventative health care. Hancock argues that health policy has been captured

by the acute sector, with smaller services being absorbed and transformed by that sector. This has involved the relocation of services, the centralisation of services and marginalising access.

With the structural changes that have occurred with the Australian health system, the development of socially based health policy initiatives has declined. A liberalist framework which supports a bio-medical approach to the health policy area has largely driven the economic changes to the system.

Ideology and health

Health policy is distinct from other policy areas in that the medical profession has taken a dominant role in shaping and constraining policy, leading to the dominance of the bio-medical model in health strategies. This model is founded on a mechanical view of the body that is a direct result of the scientific revolution. It was developed in the UK and Europe in the fight against infectious diseases, which had cost many lives until the early twentieth century. Its strengths grew as the discoveries of nineteenth century medical scientists advocated experiment and trial to combat health problems. It was seen as a time of extraordinary development in the fundamentals of public health and preventative medicine through the use of sanitation. The scientific discoveries that followed were a consequence of outbreaks of diseases, such as influenza and tuberculosis, that were treated effectively. The bio-medical model has a foundation in the life sciences: it employs large technological resources, has good records in treatment and claims to use an objective approach. The core principle behind this model is the assumption that each disease has a causal agent acting on the physical body. In this framework, social and personal factors are not considered and, consequently, only medical solutions are provided (Knight, cited in Germov, 1998, pp. 139-144).

The bio-medical model is also supported by a liberalist perspective which argues that individual lifestyle and attitudes are also causally related to health. The six general determinants of health that have been identified include four agency and medically related criteria. These criteria are:

1. Biomedical factors, weight, blood pressure and cholesterol;
2. Lifestyle and behaviour, drugs, diet, physical activity;
3. Knowledge attitudes and beliefs;
4. Genetic factors, genetic diseases.

In the current ideological framework little priority has been given to the other two determinants:

5. Environmental factors, pollution, water safety, waste disposal;
6. Social and economic characteristics, gender, ethnicity, age, class. (Germov, 1998)

The bio-medical model has dominated the policy agenda and a neo-liberalist framework has supported the agency argument of lifestyle. While in recent years there has been reference to the social, economic and environmental determinants of health, in policy documents this has had little impact on the health care system. This may be related to the lack of understanding in the requirements for structural change that uses social determinants of health as the conceptual policy framework.

Health sociology examines patterns of health and illness through societal influences. This counters the traditional view of explaining health inequality at the level of the individual, his or her biology or behaviour. Class, ethnicity and gender influence the major differentials in health,

in this model: “Australian research has consistently found a strong relationship between class and health” (Germov, 1998, p. 26).

Acheson’s (1998) report to the Blair government on health inequalities found that, despite advances in medical treatment, health inequalities between the rich and the poor continued (Shaoul, 1998). During the 1990s Australia, like other developed countries, saw income inequalities continue to increase. In 1996 the top 10% of the population owned 55% of the nation’s wealth, while the bottom 50% owned 1.6% of the available wealth, and the aggregate wealth of the richest two-hundred people in Australia grew from \$7.3 billion in 1984 to \$36 billion in 1996 (Germov 1998, p. 26). Debates have emerged regarding how poverty is to be measured, and changes in measurement by the Australian Bureau of Statistics (ABS) has made it difficult in Australia to gain comparative data after the late 1990s. A report released by NATSEM and AMP in September 2004 states that survey data suggests that levels of inequality continue to grow at a national level. ABS data from 1995-96 to 2000-01 show that the average income received by the most affluent one-fifth of the population grew by 17%, while that of the least affluent one-fifth grew by 7% (Harding *et al*, 2004, p. 3).

The Australian 2004 senate report on poverty, *A Hand Up Not a Hand Out*, has health as one of the areas identified for action. It starts by providing evidence for the link between poverty and health, and then moves into access issues. Two recommendations are presented in relation to health, one specifically stating that additional funding for preventative health is required, and that this should be directed to socio-economically disadvantaged areas. This is a simplistic recommendation because it does not outline how this will work and what type of preventative programmes will be used. The other recommendation is the renewal of the former Commonwealth Dental Program as a commonwealth-state initiative to improve access for people on low incomes (Senate Community Affairs Reference Committee, 2004, pp. 173-190). The recommendations from this report were rejected by John Howard, which has resulted in a lack of an over-arching strategy to deal with the structural social and economic inequalities that continue to grow.

Policy responses to poverty

The development of policies to reduce health inequalities, taking into account social determinants, relies on the adoption of a policy to reduce poverty and inequality. Poverty is a widely contested concept, and debates on how it should be measured continue in Australia. There are key conceptual approaches that countries are taking to develop poverty reduction policy initiatives: social capital and social exclusion. The approach taken influences the types of policy responses for reducing health inequality, with social exclusion providing a framework for the development of broader social programmes that are needed. Australia, while not having a specific poverty reduction strategy, has been using social capital as a framework for discussion in recent years.

Social capital

The concept of social capital has arisen from debates concerned with the decline of civil society, and has become widely used in the policy arena in Australia since the mid 1990’s. This decline in civic participation is seen to be the result of two main forces: neo-liberalism and social democracy. Neo-liberalists view the welfare state as having caused people to become dependent on the provisions provided. Through this process, the welfare state is seen as having taken over the role of the family and the community. This perspective takes an agency approach, with individuals and communities being seen as responsible for their well-being, and ignores the

structural inequalities that have been created through the effects of changes to the economic system.

Social democrats see market logic as driven by self-interest which, by its nature, is not communal in its perspective. A market approach is characterised by impersonality, rationalism and impermanence, which undermine trust, co-operation and mutuality (Winter, 2000, pp. 2-3). The market has evolved from pre-industrial days to a global system that is often beyond state control, with growing inequalities that have emerged through the decline in blue-collar work, thereby resulting in inter-generational unemployment. There have also been changes to industrial relation policies, such as enterprise bargaining, and increasing marginal attachment related to the increase of casual and part-time participation in the labour force. It could be argued that the decline in civil society is more of a crisis in the middle classes, and those categorised as the working or under-class have traditionally been recognised as having less formal participation in civic society. This could also be due to other structural issues, such as an increase participation in the workforce by women, who have traditionally contributed to civil society through their participation in the voluntary sector, and longer working hours for those in managerial and executive positions.

There is a limited understanding of how social capital should be defined and theoretical foundations identified. This is partially due to the multiple disciplines using this concept. Foundational ideas have evolved from classical sociology and debates that “focus on the role of norms of trust and reciprocity in shaping individual actions” (Winter, 2000, p. 21). This includes notions of social cohesion, social control, civil society and democracy. The term itself has its origins in education research, and a liberalist perspective has tended to emphasise the responsibility of individuals and communities.

Winter (2000, p. 29) compares three major analytical approaches to defining social capital.

Table. Definition, purpose and analysis of social capital.

	Definition	Purpose	Analytical scale
Bourdieu	Resources that provide access to group goods	To secure economic capital	Individuals in class competition
Coleman	Aspects of social structure that actors can use as resources to achieve their interests	To secure resources of all kinds	Individuals in family and community settings
Putnam	Trust, norms and networks that facilitate co-operation for mutual benefit	To secure effective democracy and economy	Regions in a national setting

Two crucial questions emerge from the defining models of social capital. The first is ontological in nature: is social capital an individual’s property or a property of social relationships? Bourdieu identifies social capital as an almost tangible asset that is present in individuals, relationships and networks. Coleman takes a different perspective, arguing that social capital is a functional phenomenon that is not an individual’s property, but rather a characteristic of a relationship or process. While Putman’s approach is set at a regional level, like Coleman, he argues that social capital is the result of co-operative activities. In practice, the Putman approach has often led to social capital being defined as an individual’s property in policy initiatives in

Australia. The second question is outcome focused: is social capital a commodity for the common 'good'? If it is an individual's property, then this would not be the case, and this is not determined by the nature of the approach. In Australia, social capital has been defined as an individual's responsibility, in an approach that is similar to that described by Putman.

Social capital emerged as a concept in Australia in the 1980s Social Security review into welfare policy, which raised the notion that participation in an 'active society' leads to greater social inclusion, that is, civic and social participation. The Industry Commission's 1994 inquiry into community social welfare provision found that these policy initiatives had benefited Australia, both socially and economically (Winter, 2000, pp. 4-5). Under the current government, Putman's approach has dominated the policy arena with an emphasis on volunteerism. This has impacted on the development of policies that encourage welfare participants to volunteer for charity organisations and other community activities under a 'mutual obligation' policy framework. There has also been a growth in regional development initiatives as communities undergo major economic re-structuring. Regional policy in Australia became a priority area when the government, largely under Keating, undertook major economic re-structuring, such as the removal of protections, like tariffs, from industry. The emphasis in these policy directions is that communities need to strengthen themselves with limited government input. Government initiatives in this policy area have focused on the re-development of transport systems and entrepreneurial support programmes which are often of a short-term nature (Higgins and Savoie, 1995, pp. 326-327).

After the largely unsuccessful health prevention campaigns aimed at individuals' lifestyle and behaviour in the 1970s and 1980s, there was a move, driven by the WHO, for the focus of policy to shift to community participation and healthy cities, which are defined as ones that are "continually creating and improving those physical and social environments and expanding those community resources which enable people to mutually support each other in performing all the functions of life and in developing their maximum potential" (Hancock and Duhl, 1988, cited in Baum *et al*, 2000, p. 251). Social capital was seen as a useful way to develop policies in this environment, which moved to a focus of settings such as where people live and work. This has occurred in a policy environment that is dominated by economic rationalism and liberalism, as well as a decline in funding and commitment to public health and welfare provision. This provided a policy framework that moved beyond funding programmes to stimulating communities.

The 2003 Australian Industry Commission research paper, *Social Capital: Reviewing the Concept and Policy Implications*, states that "devising policies to create social capital generally is problematic, governments should at least consider the scope for modifying policies that are found to damage social capital, and ways of harnessing existing social capital to deliver programs more effectively" (Productivity Commission, 2003, p. viii). The Australian Bureau of Statistics, in response to political imperatives of smaller government and policy interest in the concept, released an information paper, *Measuring Social Capital: An Australian Framework and Indicators*, in 2004. This paper provides a quantitative approach to the measurement of this concept that could lead to issues with the validity of responses to questions. This approach concentrates on norms, participation and networks, and while it notes the interest of public health policy in this area, it fails to provide any indicators for health status (Australian Bureau of Statistics, 2004).

Social capital has been criticised as a way for government to absolve itself from civic and social obligations, through increased responsibility being placed on individuals and communities. This approach to policy responses to poverty in Australia is supported by the liberalist ideology of agency and the economic rationalist policy framework which reduces government intervention. While the definitional and causal dimensions of the concept of social capital are still being explored in Australia, regional policy initiatives have used this as one of the key theoretical

frameworks. There have been very few studies and social policy initiatives under this framework that address the relationship of social capital and health status, or the reduction of economic inequalities. It is unlikely, due to the agency focus of this approach, that policies will be developed to reduce health inequalities that are causally related to social and economic well-being.

Social exclusion

The other approach that countries are taking, in defining poverty and developing policy responses, is through the concept of social exclusion. This concept arose in Europe in the 1970s, when there was a sharp increase in the number of poor as a result of economic reform.

European debates about social exclusion are more concerned with social relations and ruptures to the social contact. They are implicitly focused on sub-sets of the low-income population who are distinguished within themselves and from the 'mainstream' by location, attitudes and behaviour. Not all low-income people are excluded from society, nor do all excluded people have low income. (Whiteford, 2001, cited in Saunders, 2003, p. 5)

Atkinson (1998, cited in Saunders, 2003, p. 7) identifies three conceptual dimensions of the definition of social exclusion. Exclusion is relative, and can only be judged in comparison with the circumstances of others (individual, group or community) in a given place and time. The dynamic nature of this characteristic approach does not lend itself to a policy area such as health, which has a diminishing capacity to provide for the diversity of needs due to structural changes that have recently occurred. The agency argument in the exclusion approach expands to the idea that people are excluded by acts of the agent or agents. This runs counter to notions of individual responsibility that have dominated policy initiatives in recent years. The third conceptual dimension relates to dynamics, where characteristics of exclusion and its adverse effects may only become apparent over time, as an accumulated response. As with the other dimensions, this approach is at odds with structural and ideological changes, namely, the move to a short-term focus in policy making. While being an exclusion approach to health inequality, it is constrained by structure and ideology.

Jones and Smyth (1999, cited in Saunders, 2003) identify five potential benefits of moving to an exclusion framework to analyse poverty.

1. It broadens the analysis of the problem and policy responses;
2. Provides a bridge to discussions of equality and citizenship;
3. Provides a basis for understanding the peculiarities of difference;
4. Highlights the spatial dimensions of exclusion, and;
5. Facilitates cross-national comparisons.

Despite the structural and ideological barriers to implementing an exclusion framework, the UK adopted a social exclusion framework as the basis for major welfare reforms aimed at reducing inequality. In 1997, under the Blair government the Social Exclusion Unit was established, which aims to use geographical information to increase the awareness of citizens and urban planners about the different dimensions of disadvantaged areas. Social exclusion has been defined by this unit as

a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high

crime environments, bad health and family breakdown. (Social Exclusion Unit, 2004, p. 7)

While the Blair government initiatives in this area have included a commitment to reduce health inequality, the policy initiatives under this strategy have been mainly educationally focused. And while the links between social determinants and health inequalities and needs for holistic cross-agency policy initiatives are cited in policy documents, they still rely on the National Health Service to meet the target of a 10% reduction in health inequality by 2010 (Horton, 2002).

Social theories

Durkheim's concept of anomie and Marx's concept of alienation are not dissimilar to the notion of social exclusion specifically, and to a lesser degree social capital. While Marx wrote directly about employees' alienation from the system of production and the good produced, notions of social exclusion refer to individuals being excluded from the wider capitalist system. If the four types of alienation are examined with this idea in mind, then they seem to be comparable to the social exclusion framework (Blauner, 1964) and highlight the capitalist system itself as a barrier to reducing exclusion.

Marx originally envisaged powerlessness as occurring in the impersonal systems that technology had created in the workplace, and which limited workers' control and freedom so they react rather than act. It could be argued that this powerlessness has spread where there are groups of people who are powerless to access the capitalist system altogether. Meaninglessness was seen as being related to the worker relationship to the product, process and organisation that had diminished as a result of the division of labour. As with the notion of powerlessness, meaninglessness could also be related to the lack of meaning from the system of capitalism itself.

Social isolation relates to notions of integration and membership of communities, and Durkheim saw the disintegration of communities as a product of anomie or normlessness. This is similar to the underlying concepts that are used in the notion of social capital and exclusion, where urbanisation and industrialisation are perceived as having "destroyed the normative structure of a more traditional society and uprooted people from the local groups and institutions which had provided stability and security" (Blauner, 1964, p. 24). There have been continuing declines in membership of unions and political parties in Australia, which can be seen as a response to increasing isolation from civil and social activities.

Self-estrangement refers to the notion that workers may become alienated from their inner selves due to the nature of the work they undertake. This could again be seen on a larger scale, where notions of self are seen as becoming more fluid and changeable with the increase in the specialisation and casualisation of the workforce, and where the nature of capitalism is dependent on individuals seen as commodities. It could be further argued that the system of production, rather than the act of production, has become a source of self-estrangement.

Liberalism and market ideology, together with the related structural reforms to health and welfare delivery, act as conceptual barriers for social exclusion policy initiatives in the reduction of exclusion. Despite these barriers, an increasing number of OECD countries are using the exclusion framework to develop policies to reduce levels of social and health inequality. One of the benefits of using this approach is that it takes into account the complex nature of poverty and advocates holistic policy approaches for improving well-being. The WHO's current policy directions use an exclusion framework. It will be interesting to watch Australia's future policy responses in this area, as it traditionally follows the policy directives of this organisation.

WHO policy directives

In 1998, the WHO released its report, *Social Determinants of Health: The Solid Facts*, which provided strong evidence of the social determinants that effect health status. This report stated that there had been little change in the way that policy was used to tackle the problem, and a change in policy direction “could have far-reaching implications for the way that society makes decisions about development, and it could challenge the values and principles on which institutions are built and progress is measured” (Wilkinson and Marmot, 1998, p. 4) This report outlines ten inter-related aspects of the social determinants of health:

1. Need for policies to prevent people from falling into long-term disadvantage;
2. How the social and psychological environment affects health;
3. Importance of a good environment in early childhood;
4. Impact of work on health;
5. Problems of unemployment and job insecurity;
6. Role of friendship and social cohesion;
7. Dangers of social exclusion;
8. Effects of alcohol and other drugs;
9. The need to ensure access to healthy food for all;
10. The need for healthier transport systems. (Wilkinson and Marmot, 1998, p. 7)

In 2003, the WHO released a second edition of this report, which provides scientific evidence to support policy change, and documents evidence for the relationship between social determinant and health (Wilkinson and Marmot, 2003).

The report, *Social Determinants of Health: The Solid Facts*, has a chapter on the relationship between social exclusion and health, and the growth in unemployment and poverty (Wilkinson and Marmot, 1998, pp. 16-18). In this report it is argued that

processes of social exclusion and the extent of relative deprivation in a society have a major impact on health and premature death. The harm to health comes not only from material deprivation but also from the social and psychological problems of living in poverty. (Wilkinson and Marmot, 1998, p. 14)

This report identifies four broad policy responses that could be used to reduce health inequality. One strategy that most OECD countries, including Australia, advocates is the adoption of legislation to protect the rights of minority groups. The second policy directive is the implementation of public health interventions for removing barriers of access to services. In Australia, structural changes to the health care system has resulted in the centralisation of services and the reduction of access for rural and remote communities. Even though there have been studies which have shown that those with higher socio-economic status have better health, these people have greater service provision in their areas, and higher levels of access to services than those with lower socio-economic status and related poor health. To reduce exclusion, the WHO in this report advocates the development and maintenance of income support, adequate minimum wages, education and employment policies. While most OECD countries have a tradition of policy initiatives in these areas, under the structural changes that have occurred as part of the economic reform agenda many of the conditions and services in these areas have been eroded. In Australia, fees for tertiary studies have been introduced, there has been a decline in union membership, an introduction of enterprise bargaining agreements and the casualisation of the workforce. The final policy directive in the report is for income and wealth redistribution for reducing inequalities and relative poverty, and for moving towards a more egalitarian society. While in the majority of OECD countries there are safety-net health and welfare provisions by

the government, there is a direction in government, driven by economic reforms, to reduce responsibilities in these areas. This is occurring in an environment characterised by a growth in inequality, where the gap between the rich and the poor continues to grow. The final two directives require strategies to reduce inequality in society as a method to improve health status.

Currently in Australia, poverty policy is a low priority for the government. Despite ideological and structural barriers, social exclusion approaches are being used to develop poverty strategies in a growing number of countries. In Australia, policy directions in health have taken a traditional bio-medical approach, and social capital is being explored as a conceptual foundation for developing strategies for disadvantaged communities. While the identification of social capital variables may be useful, the complex nature, health inequality and the relationship with poverty are described more completely in the social exclusion approach. The outcomes for the policy initiatives that have been implemented are long-term in nature, so at this stage it is not possible to examine their effectiveness. It will be interesting to see if appropriate programmes can be developed with the structural and ideological constraints of health care delivery systems in countries such as Australia.

Conclusion

It is unlikely, in countries like Australia, that without major economic changes at an ideological and structural level that economic and health related inequalities will decline. With the current system in place, it is more likely that inequalities will grow. The notion of liberalism has provided an agency approach to the development of policy in a climate of economic reform and continuing devolution of government responsibility to individuals and communities. In this environment the dominance of the bio-medical model and the agency view of lifestyle dominate the health policy arena. In Australia, where poverty has been a low priority in the policy process, social capital has provided the framework for a regional policy agenda aimed at identifying and providing stimulants to communities, which are largely seen as being responsible for their own economic and social well-being. Social capital has been used as a conceptual basis for many of these policy initiatives. Social exclusion, as an approach, has a sounder conceptual basis in its definition of poverty and its relation to health and well-being. This framework has been used, then, to identify broad policy directions for reducing inequality through policy change. While these strategies appear to be appropriate responses to the problem, there are significant structural and ideological barriers for policy initiatives to develop. The WHO has had significant influence on policy directions that countries take. It is essential for initiatives to be developed from a social perspective if health inequality is to improve, despite the structural and ideological barriers.

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