Equity

Healthcare for all patients regardless of circumstance

Equity means that healthcare should be provided:

- On the basis of clinical need, regardless of personal characteristics such as age, gender, race, ethnicity, income, socioeconomic status or geographical location
- To reduce differences or disparities in health status across various sections of the population.

Equity in health and healthcare has been described as:

". . . grounded in the principle of distributive justice. [It] reflects a concern to reduce unequal opportunities to be healthy associated with membership in less privileged social groups, such as poor people; disenfranchised racial, ethnic or religious groups; women and rural residents."[1]

Treating patients equitably and on the basis of clinical need for healthcare remains a fundamental goal of the NSW public healthcare system.

This chapter covers:

- Data on three population groups within NSW according to rurality, Aboriginality, and socioeconomic status (SES). For each of these groups, we report differences in life expectancy and then present two supplementary indicators of disease burden, care delivery or outcomes
- International comparisons of the impact of income on self-reported health status and confidence of receiving the most effective treatment.

Several charts in this chapter separate the population into five bands (quintiles) according to the level of disadvantage ranging from the most deprived (poorest) to the least deprived (richest). Due to data limitations people are classified into socioeconomic status based on the average characteristics of their local area or postcode, rather than their individual circumstances.

We use the term Aboriginal, rather than Aboriginal and Torres Strait Islander in line with NSW Health usage, which recognises that Aboriginal people are the original inhabitants of NSW. However where we have drawn data from national sources (ABS), we have retained the terminology of the source material.

What we learnt about NSW	How does NSW compare internationally?		
	Higher ranking	Middle ranking	Lower ranking
People living in rural NSW generally have a lower life expectancy and self-reported health status than their metropolitan counterparts	No comparative international data available		
Compared to those living in urban areas, people in rural NSW have higher rates of potentially preventable hospitalisations			
Life expectancy at birth is significantly lower for Indigenous people compared to non-Indigenous people	No comparative international data available		
Compared to non-Aboriginal mothers, Aboriginal mothers are more likely to have low birth weight or pre-term babies			
Aboriginal people are more likely to be hospitalised for a range of medical conditions than non-Aboriginal people			
People living in more socioeconomically disadvantaged areas have more health problems but do not always receive more healthcare	No comparative international data available		
In terms of how people report their health status and confidence in getting effective care, there are significant gaps between those on above average and those on below average income		■	

Rurality and health disparities

People living in rural NSW generally have a lower life expectancy than those in cities

Across Australia, people living in rural and remote areas generally have worse health than their city counterparts. Many factors contribute to this disparity, including for example: socioeconomic disadvantage; higher rates of smoking and alcohol abuse; difficulties accessing healthcare services; and greater occupational risks from farming or mining work. In addition, there is poorer health among Aboriginal people, who comprise a significant proportion of the population in rural and remote areas.[2]

For 2002-2006, life expectancy at birth showed a clear relationship with rurality, decreasing as levels of remoteness increased (Figure 6.1).

The 2009 NSW Population Health Survey found that people living in rural NSW reported higher levels of chronic illness and health risk factors than those in urban areas. Despite this, there was no significant difference between the two groups in the percentage of people visiting the GP in the preceding two weeks. Those in rural areas were more likely to have accessed community health care services and visited the ED in the previous year. Importantly, people in rural NSW were more likely to report experiencing difficulties accessing healthcare when they needed it (Figure 6.2).

People living in rural NSW have higher rates of 'potentially preventable hospitalisations' (PPHs). Typically, these conditions (asthma, congestive heart failure, angina, chronic obstructive pulmonary disease and diabetes) can be treated effectively to avoid hospitalisation. In 2008-09, the rate of PPHs among residents of very remote areas was 2.3 times higher than the rate for residents of major cities (Figure 6.3).

Areas with higher levels of ill-health should receive higher rates of service provision and higher rural hospitalisation rates may reflect this.

Figure 6.1: Life expectancy at birth, by rurality, NSW, 2002-2006◊

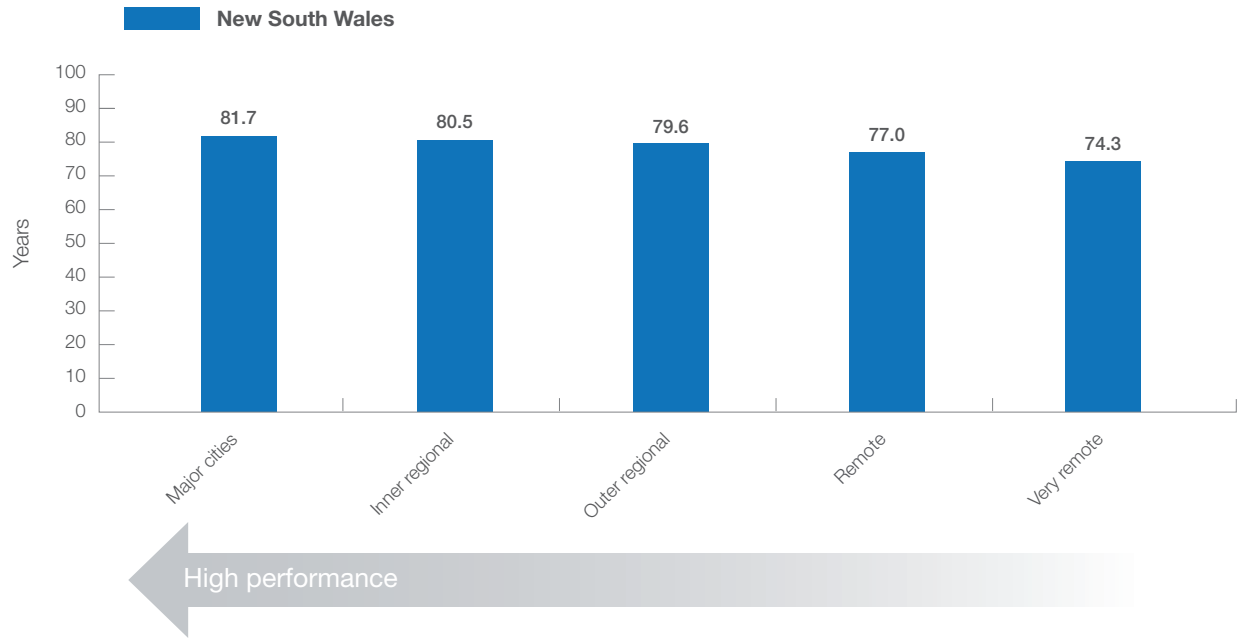


Figure 6.2: Self-reported health status, use of services and difficulties accessing care, NSW, 2009Ω

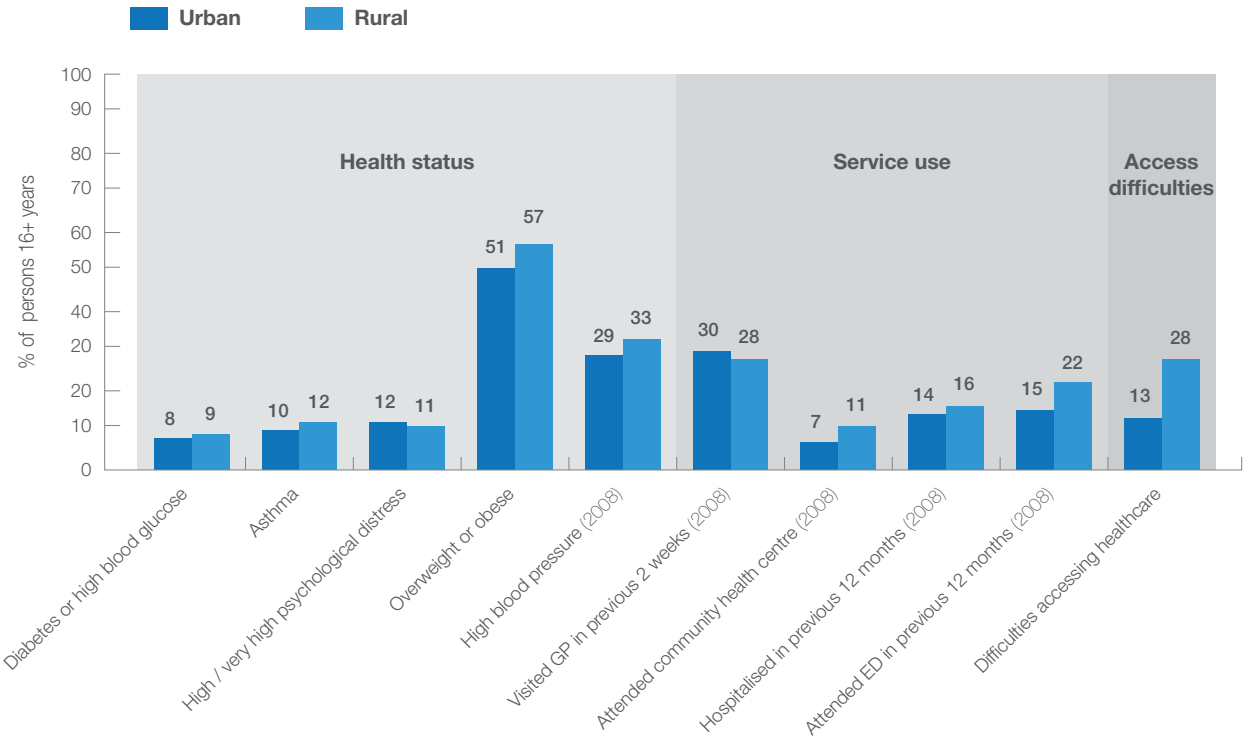
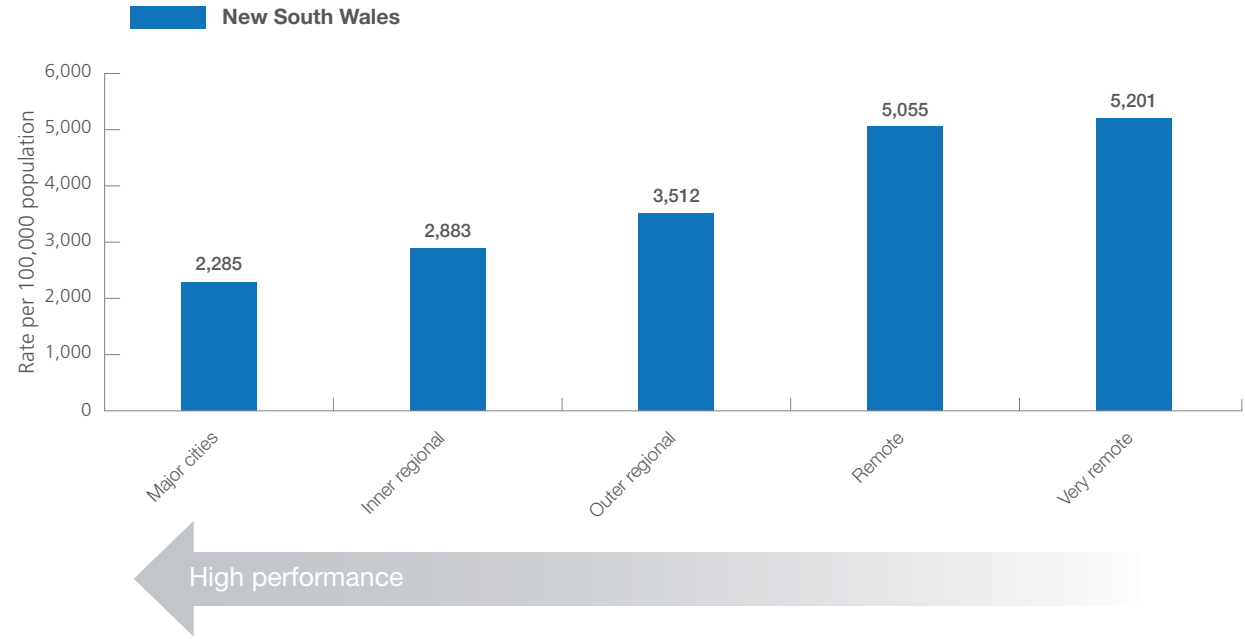


Figure 6.3: Potentially preventable hospitalisations, NSW, by rurality, 2008-09Ω



(◊) Australian Bureau of Statistics mortality data and population estimates; (HOIST) Centre for Epidemiology and Research, NSW Department of Health.
(Ω) NSW Population Health Survey, Centre for Epidemiology and Research, NSW Department of Health.
(◊) (Ω) ARIA+ classifies areas as major cities, inner regional, outer regional, remote and very remote on the basis of their remoteness from access to goods and services.

Aboriginal people and health disparities

Aboriginal people have poorer health than non-Aboriginal people

Around 160,000 Aboriginal people live in NSW, making up 2.3% of the total population and around a third of the total Australian Aboriginal population. Around 5% of Aboriginal people in NSW live in remote or very remote areas.[3]

A range of data show that Aboriginal people are significantly disadvantaged compared to non-Aboriginal people in terms of health and health risk factors such as socioeconomic status, smoking, alcohol misuse and low physical activity.[2]

In maternal and infant health, when compared to the rest of the NSW population, Aboriginal women are less likely to receive antenatal care in the first 14 weeks of their pregnancy. They are more likely to smoke during pregnancy and more likely to have low birth-weight and premature babies. (Figure 6.4).

Life expectancy at birth is significantly lower for Aboriginal people compared to the non-Aboriginal population. The difference between the populations in NSW is smaller than in Australia as a whole (Figure 6.5).

Aboriginal people are more likely than the total population to be hospitalised. In 2006-07 age adjusted hospitalisation rates for Aboriginal people were around 1.6 times the rates for the non-Aboriginal population. Figure 6.6 shows sizeable disparities in hospitalisation rates across the two groups for common medical conditions.

High levels of health service use by Aboriginal people reflect differences in health status between Aboriginal and non-Aboriginal populations.

Figure 6.4: Maternal health measures, Aboriginal and non-Aboriginal population, 2006 and 2008[Δ]

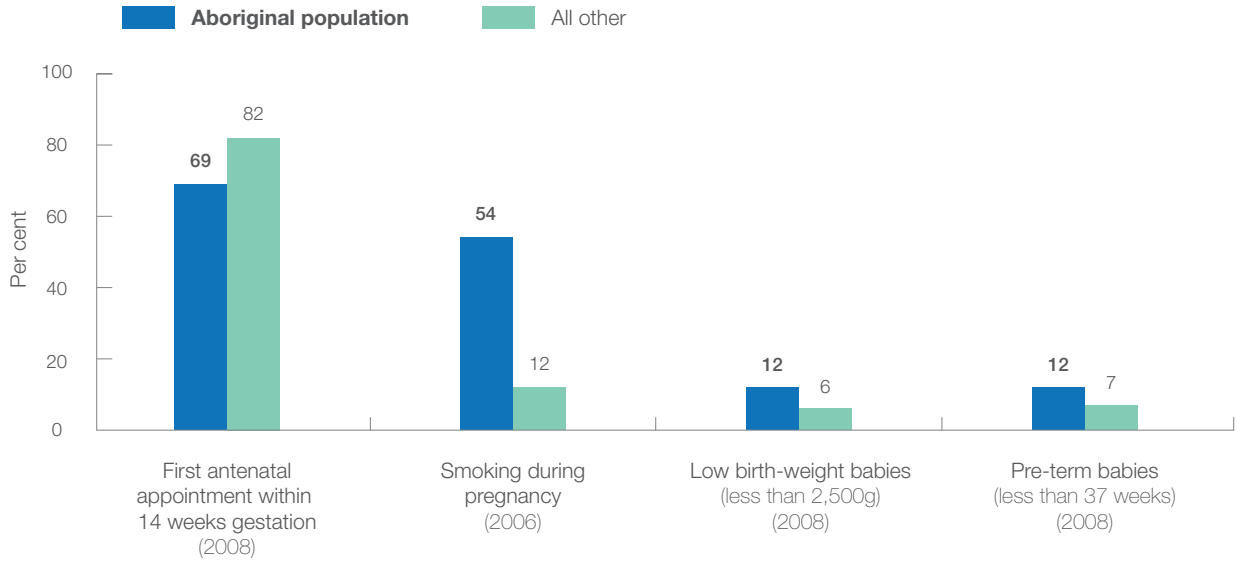


Figure 6.5: Life expectancy at birth by Indigenous status, NSW and Australia, 2005-2007◊

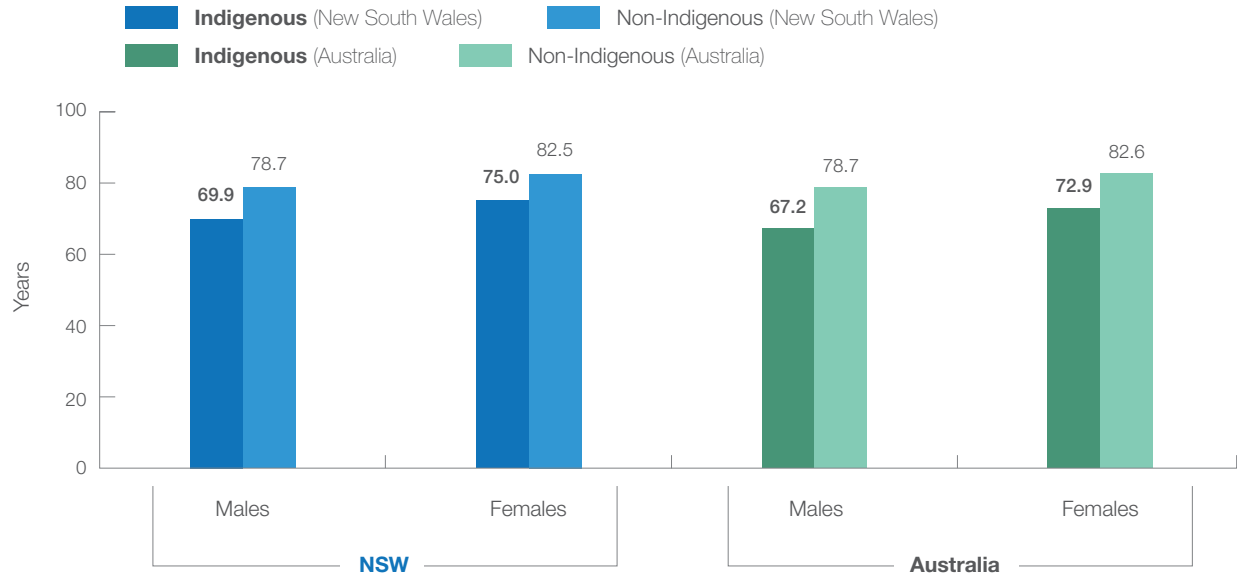
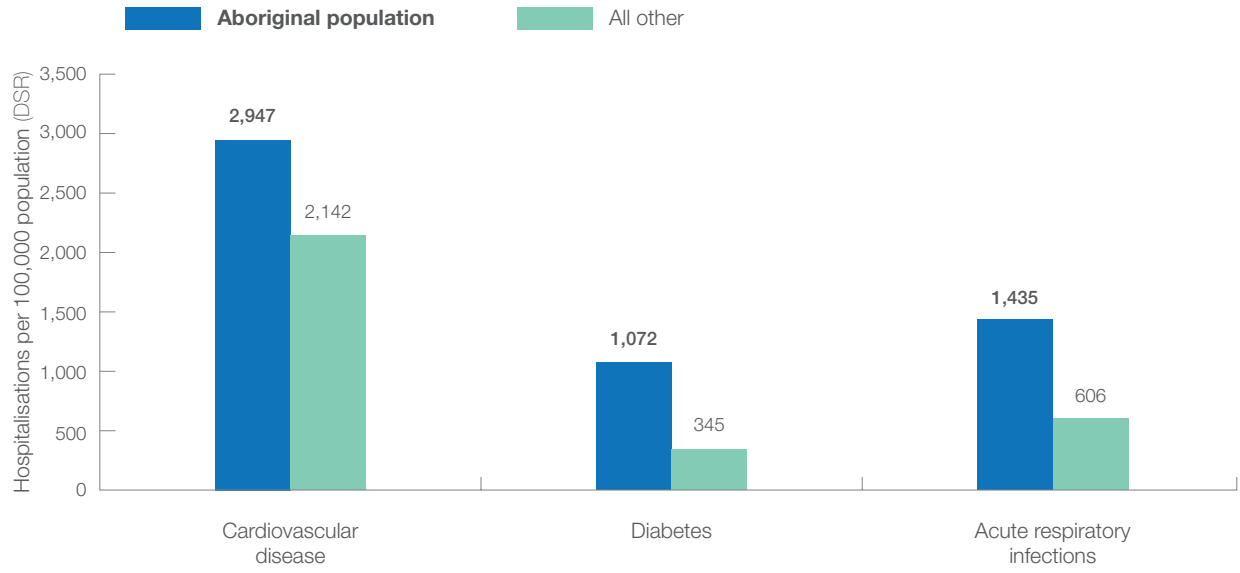


Figure 6.6: Hospitalisation rates, Aboriginal and non-Aboriginal population, NSW, 2006-07π



(Δ) Centre for Epidemiology and Research: The Health of the people of NSW-report of the Chief Health Officer. Summary report, 2010; NSW Health. Mothers and babies 2006.
(◊) Australian Bureau of Statistics: The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples.
(π) Centre for Epidemiology and Research: The Health of the people of NSW-report of the Chief Health Officer. Summary report, 2010. (Note: DSR is directly standardised rate).
Note: We use the term Aboriginal, rather than Aboriginal and Torres Strait Islander in line with NSW Health usage, which recognises that Aboriginal people are the original inhabitants of NSW. However where we have drawn data from national sources (ABS), we have retained the terminology of the source material.

Socioeconomic disparities

People in disadvantaged areas have more health problems but do not always receive more care

Although the overall level of health and wellbeing of NSW people is high compared to other countries, there are considerable disparities in the health status of different socioeconomic groups across the state.

The life expectancy for a person born in NSW in 2006 is 81.8 years[4]. While life expectancy increased for all socioeconomic groups in NSW between 1995 and 2006, the 'gap' in life expectancy between the lowest and highest socioeconomic groups increased. For people who were born in 1995, those in the least disadvantaged socioeconomic group are expected to live 2.6 years longer than those born in the most disadvantaged socioeconomic group. For those born in 2006, this gap increased to 3.7 years (Figure 6.7).

While people in lower socioeconomic groups are more likely to have long-term health conditions, this increased need is not always matched by increased use of healthcare services or treatment rates. For example, people living in the lowest socioeconomic communities were almost twice as likely to report they had been diagnosed with heart disease or other circulatory diseases (Figure 6.8). Yet procedure rates for cardiac interventions such as coronary artery bypass grafts (CABG) or coronary angioplasty do not reflect this higher prevalence (Figure 6.9).

Figure 6.7: Life expectancy at birth, by socioeconomic status, NSW, 1995 and 2006◊

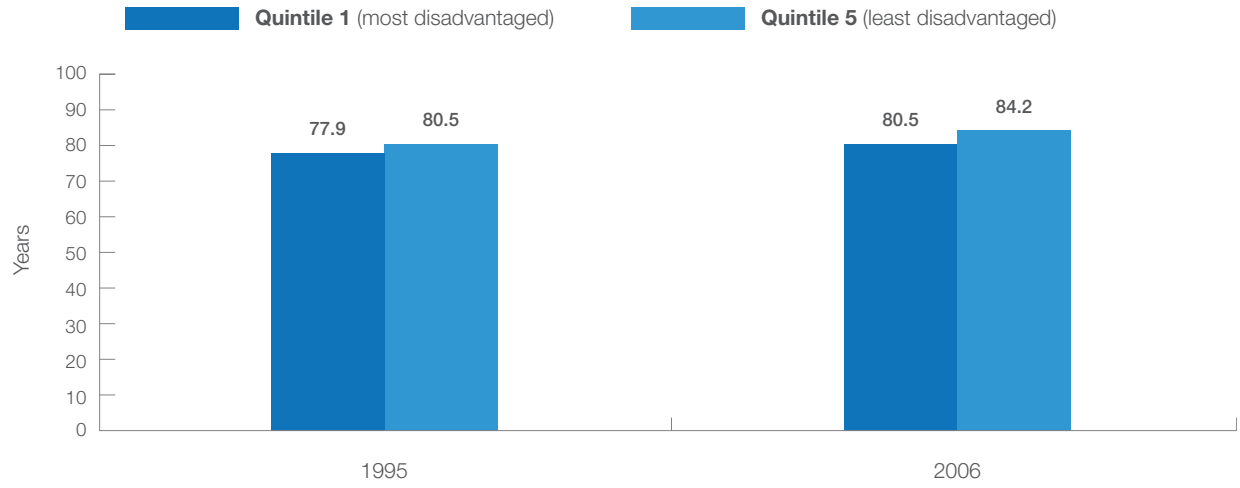


Figure 6.8: Self-reported morbidity, by socioeconomic status, NSW, 2007-2008[ð]

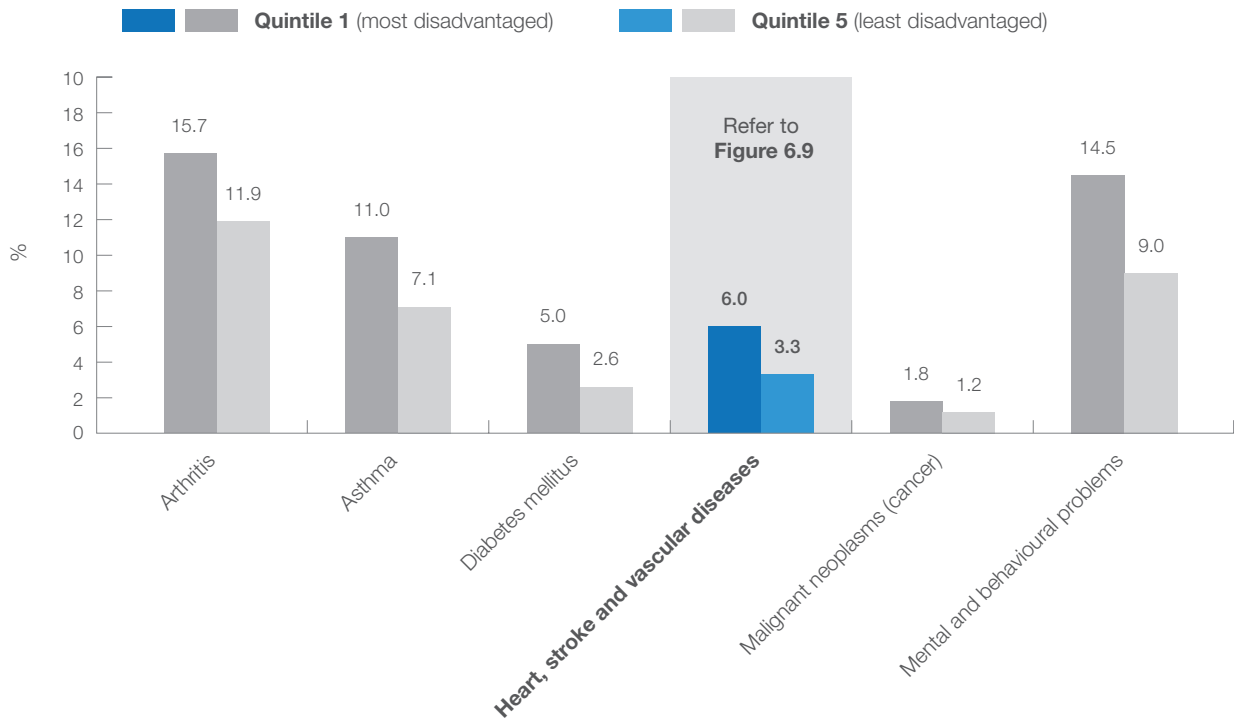
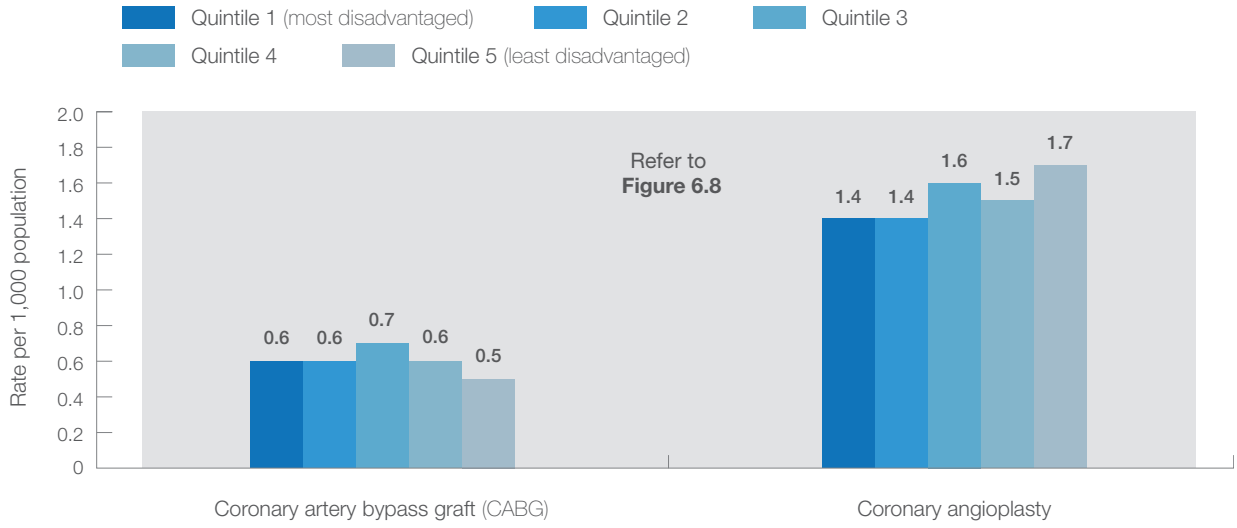


Figure 6.9: Cardiac procedures, by socioeconomic status, NSW, 2007-08[µ]



(◊) Australian Bureau of Statistics mortality data and population estimates; (HOIST) Centre for Epidemiology and Research, NSW Department of Health.
(ð) Australian Bureau of Statistics National Health Survey, 2007-2008.
(µ) COAG NHA Table 48.2 citing National Hospital Morbidity Database (Note: Includes public and private use of hospitals).

Income gaps: international context

Income affects health status and confidence in receiving care

Indicators of equity usually focus on disparities within the population served by a healthcare system. International surveys provide an opportunity to place any differences in context — allowing comparisons of the 'gap' between subgroups within different populations.

The graphs on these pages illustrate international data on the 'income-associated gap', which depicts differences between adults reporting above average and below average income.

So, for example, on the question of self-reported health status, 68% of NSW adults with above average income said their health was excellent or very good, compared to 45% of those with below average income. The 'income-associated gap' is the difference – or 23%. Internationally, the smallest gap in self-reported health status was recorded in New Zealand (14%) and the largest in the United States (33%) (Figure 6.10).

In terms of whether adults are confident they will receive the most effective treatment should they become seriously ill, NSW had a 9% income-associated gap. The United States had the biggest gap at 26% (Figure 6.11).

The differences in NSW suggest that people's views on health and confidence in receiving care are related to their income.

Figure 6.10: **Survey 2010:** Self-reported health status; excellent or very good, above average and below average income*

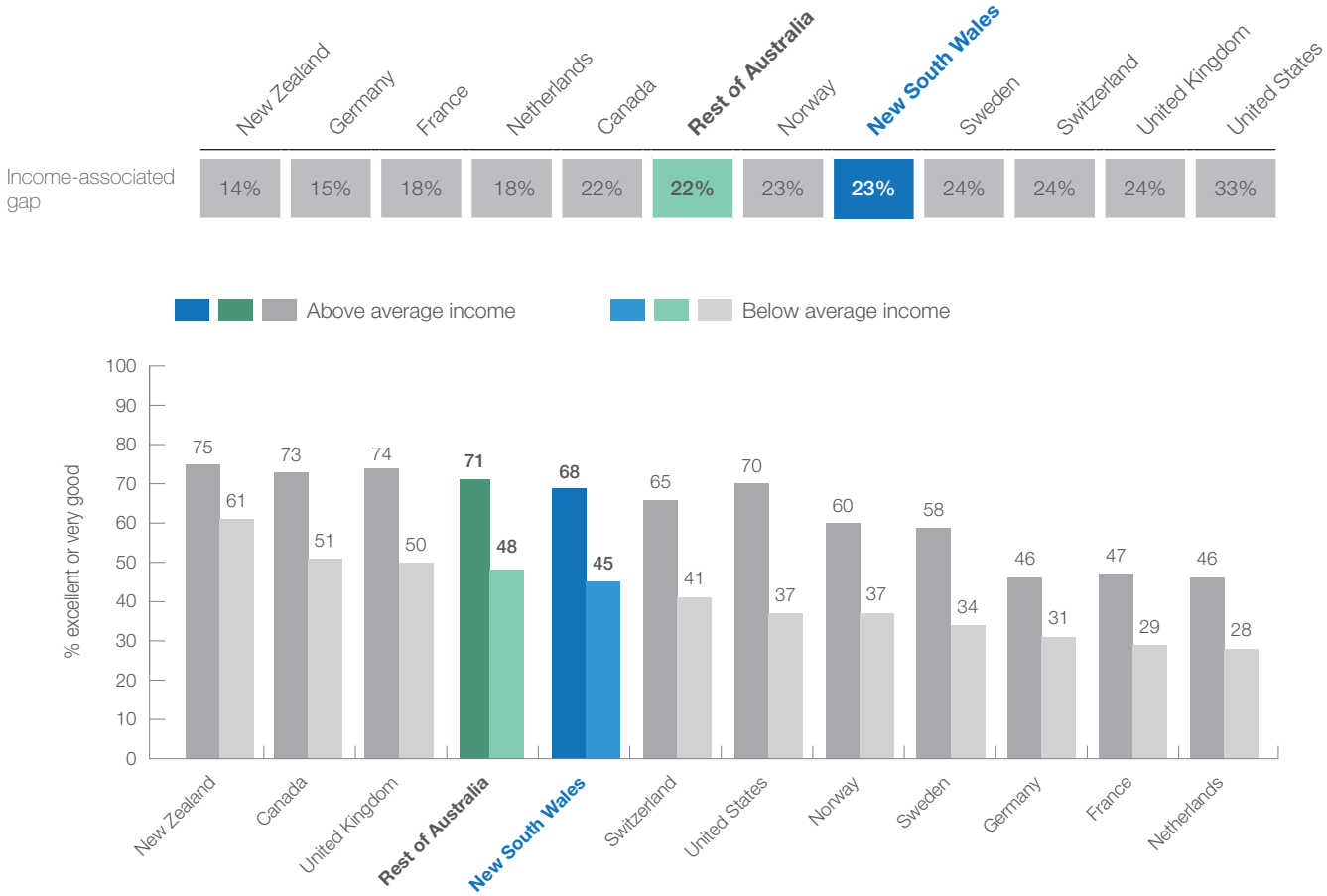
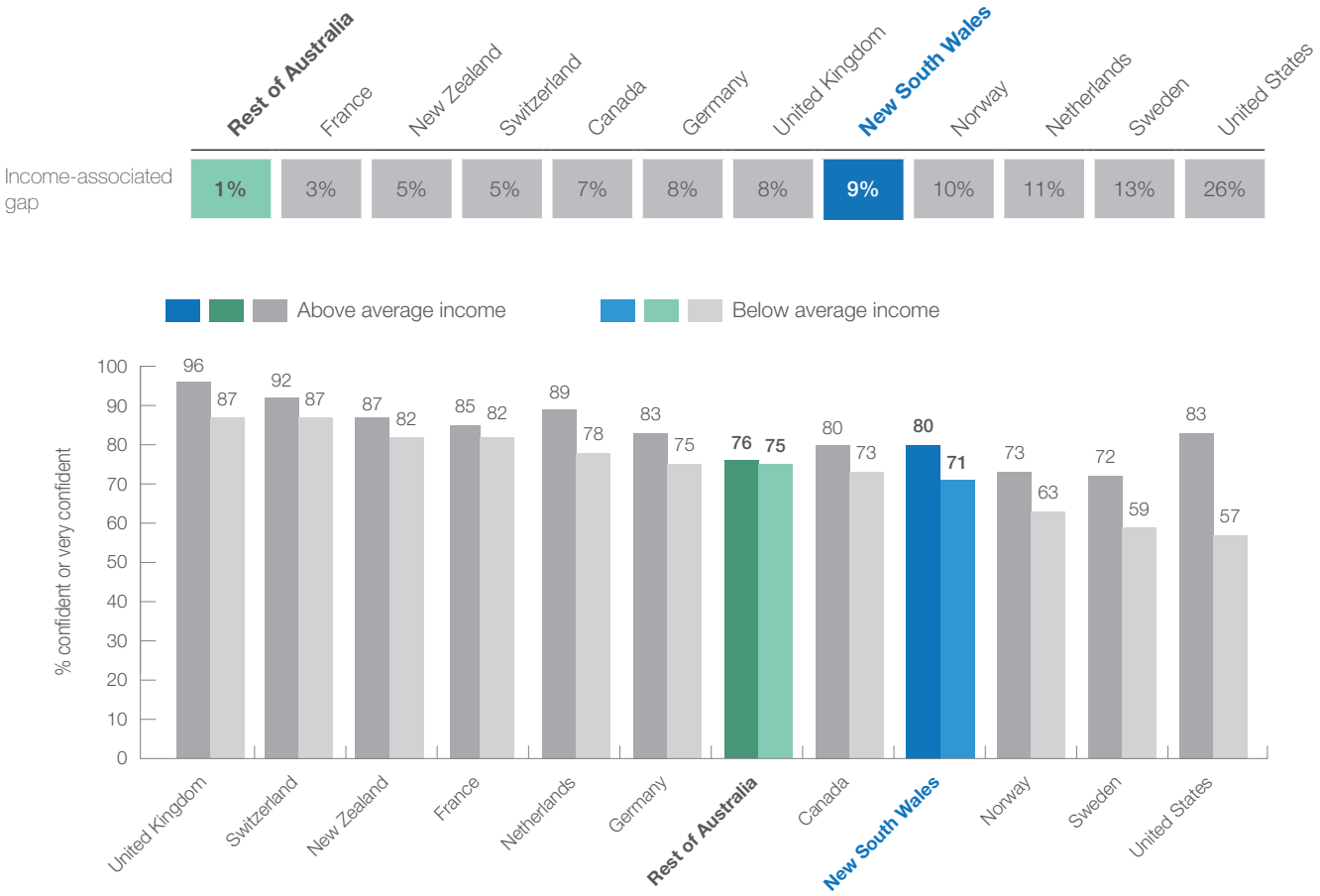


Figure 6.11: **Survey 2010:** How confident are you that if you become seriously ill you will receive the most effective treatment, including drugs and diagnostic tests?
very confident / confident responses, above and below average income*



(*) 2010 Commonwealth Fund International Health Policy Survey (Notes: Percentages may not add up to 100 due to rounding; income gaps derived from rounded data; for bar graphs, countries are sorted by below average income).