The Social Gradient in Health: Trends in 20th Century Ideas,
Australian Health Policy 1970-1998, and A Health Equity Policy
Evaluation of Australian Aged Care Planning

Brian James Fleming
Department of Public Health
University of Adelaide
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Abstract

Inequalities in health, which I prefer to call the social gradient in health, have been observed for centuries. Since the late 1970s, there has been increasing international attention paid to the topic, growing exponentially in the late 1990s. In Europe and the USA, theories explaining the existence of a social gradient in health abound, yet have changed markedly over time, and this history is presented as a novel map of ideas. Despite the variety of theories, the social gradient in health remains, and may be growing steeper. Theories of the production of good health are similarly varied, and have also changed over time. There are substantial parallels between the two sets of theories. Regrettably, developed and developing countries separated their health conferences, parking certain theories away from developed countries’ gaze. Australian research has contributed some important descriptive work.

Australian policy interest in the topic, at the national level, waxed and waned from 1970 to 1998, only once reaching a threshold where it transferred into policy action that was likely to have any attenuating impact on the social gradient in health. The department responsible for health is consumed by its relationships with, and expenditure upon, health services. An iterative policy loop within the department ensures that interest in the social gradient in health by middle level staff does not affect pragmatic concerns, with disease, at more senior levels.

Three policy dimensions are suggested for attention, one material/macro-social, another the workplace/individual and one concerned with the reproduction of the social gradient in health over time. Among suggestions for policy change is one for the national health department to examine funded programs from the perspective of a social gradient in health. Australian aged care planning policy is evaluated this way, in an example of research-to-policy transfer. It is shown that there is a spatial gradient in age at entry of women to residential aged care in South Australia, consistent both with the spatial distribution of socioeconomic circumstances and generally with gradients in health persisting into old age. A model of resource distribution is developed, based on spatial gradients in mortality.
Contents

Abstract ......................................................................................................................... 8

Introduction: why look at inequalities, or the social gradient in health? ....................... 1

Chapter 1. Explanations for the (increasing) social gradient in health ......................... 6

In a detailed introduction to the main players and the range of ideas, this chapter introduces a taxonomy of explanations for the social gradient in health. These elaborations add to and modify the explanations in the Black Report, 1980.

Chapter 2. Explanations for good health ....................................................................... 50

There is a variety of explanations for good health, or rising life expectancy. This topic is not developed extensively in the relevant literature, but is important because attempts to improve health, based on particular explanations, may act perversely to steepen the social gradient in health.

Chapter 3. Australia: the social gradient in health and material inequality ............... 75

The social gradient in mortality by measures of socioeconomic status is similar to other developed countries, particularly Anglophone ones. The Australian work is predominantly descriptive, rather than theoretical, while the social explanatory framework in government health publications is predominantly behavioural.

Chapter 4. A history of ideas about inequalities in health ........................................... 92

It is illuminating to map influential research into the social gradient in health in an historical context, by exploration. An accumulation of anomalies and failures in individualist explanations drove research toward social and structural explanations, which had been little explored. This direction is, however, against the current balance of forces that favor particular explanations.

Chapter 5. Power and the welfare state ....................................................................... 113

I describe two analytical tools that are used in the following three chapters to explore policy making about the social gradient in health, particularly in Australia.

Chapter 6. Policy dimensions ..................................................................................... 159

I set out the main reasons advanced for action, arguing that health matters to Australians and that social distribution strikes at one of the publicly held moral values of Australians: that of fairness. I suggest three policy dimensions to aid thinking about policy action: a social dimension, an individual dimension and, a dimension for the reproduction of the social gradient in health.

Chapter 7. Australian health policy and the social gradient in health ....................... 142

A variety of documents used at high levels in health policy formulation reveals that Australia is in a weak position to include materialist, relative-materialist and political explanations for the social gradient in health in the evidence base for a health production or health-creation agenda.

Chapter 8. What should the Department of Health do? .............................................. 165

I draw together the conclusions from the previous seven, more conventionally analytic chapters, to speculate on what action might be taken by a Department of Health that was keen to make a difference to the social gradient in health.

Chapter 9. Health equity evaluation of a specific policy domain - Aged Care .......... 179

I show that the existing policy approach to planning services for older Australians contains a structural bias that delivers relatively more services to areas with higher socioeconomic profiles. I also demonstrate an alternative approach, based on mortality, which would make for a fairer and more rational, graded, targeting of resource.

Thesis conclusion ....................................................................................................... 218

References .................................................................................................................. 221