5.1 Health across socioeconomic groups

Socioeconomic factors are important determinants of health and wellbeing in Australia. The higher a person's income, education or occupation level, the healthier they tend to be—a phenomenon often termed the 'social gradient of health'. In general, people from lower socioeconomic groups are at greater risk of poor health, have higher rates of illness, disability and death, and live shorter lives than those from higher groups (Mackenbach 2015). In 2001–2007, for example, men and women aged 20 in the lowest socioeconomic group could expect to live 2.6 years less than those in the highest group (Clarke & Leigh 2011).

Socioeconomic position can be measured using a single characteristic, such as income, education, or occupation, or a composite measure such as the Index of Relative Socio-Economic Disadvantage (IRSD). This snapshot uses the IRSD, which is compiled by the Australian Bureau of Statistics after each Census of Population and Housing using area-based population attributes such as low income, low educational attainment, high unemployment and jobs in relatively unskilled occupations (see 'Chapter 4.1 Social determinants of health'). The IRSD reflects the overall or average level of socioeconomic disadvantage of the population of an area; it does not show how individuals living in the same area differ from each other in these socioeconomic factors. In this snapshot, people living in the lowest socioeconomic areas are also referred to as the 'lowest socioeconomic group', and those living in the highest socioeconomic areas as the 'highest socioeconomic group'.

People in the lowest socioeconomic group are compared with the highest group on selected health measures, including health risk factors, chronic diseases and causes of death. On almost all of these measures, people in the lowest socioeconomic group fared worse.

- On average, those in the lowest socioeconomic group were far more likely to smoke daily. In 2013, 20% of those aged 14 and over in this group smoked daily, a rate 3 times that of people in the highest socioeconomic group (6.7%) (Table 5.1.1).
- For lifetime risky drinking of alcohol, people in the lowest socioeconomic group had a lower rate. In 2013, these adults were less likely to exceed alcohol consumption guidelines than adults in the highest socioeconomic group (16.4% compared with 18.5% respectively).
- On other health risk factors—inadequate fruit and vegetable consumption, dyslipidaemia (abnormal amounts of lipids such as cholesterol in the blood), and impaired fasting glucose levels—there were no significant differences between people in the lowest and highest socioeconomic groups.

Table 5.1.1: Inequalities in selected health risk factors

	Year	Lowest socioeconomic group (%)	Highest socioeconomic group (%)	Rate ratio: lowest/highest socio-economic group
Low birthweight	2013	7.5	5.6	**1.3**
Daily smoking	2013	20	6.7	**3.0**
Inactive or insufficiently active	2014–15	76	56	**1.4**
Lifetime risky drinking	2013	16.4	18.5	**0.9**
Overweight or obese	2014–15	66	58	**1.1**
High blood pressure	2014–15	26	21	**1.2**
Participation of women aged 20–69 in cervical screening	2012–13	52	64	**0.8**

Sources: ABS 2015; AIHW 2014a, 2015a, 2015b.

- The prevalence of some chronic diseases was substantially higher among adults in the lowest socioeconomic group. Diabetes, for example, was 2.6 times as high, and coronary heart disease and stroke 2.2 times as high, as for those in the highest socioeconomic group (Table 5.1.2).
- Lung cancer incidence was 1.6 times as high in the lowest socioeconomic group as for the highest group in 2006–2009 (rates of 52 and 33 per 100,000 population respectively), reflecting the higher rates of smoking in the lowest socioeconomic group.
- Adults from lowest income households were far more likely to rate their oral health status as 'fair' or 'poor', compared with adults from the highest income households (31% compared with 12%, respectively).

Table 5.1.2: Inequalities in selected chronic diseases

	Year	Lowest socioeconomic group (%)	Highest socioeconomic group (%)	Rate ratio: lowest/highest socio-economic group
Arthritis	2014–15	19.7	12.1	**1.6**
Asthma	2014–15	12.8	9.8	**1.3**
Back problems	2014–15	18.9	15.9	**1.2**
Chronic kidney disease	2011–12	13.5	8.3	**1.6**
Coronary heart disease	2011–12	5.0	2.3	**2.2**
Diabetes	2014–15	8.2	3.1	**2.6**
Lung cancer incidence	2006–2009	52 per 100,000	33 per 100,000	**1.6**
Mental and behavioural problems	2014–15	21.5	15.0	**1.4**
Oral health rated as fair or poor[(a)]	2010	31.2	12.2	**2.6**
Stroke	2014–15	1.1	0.5	**2.2**

(a) Classified by household income groups.

Sources: ABS 2015; AIHW 2013, 2014b, 2014c.

- Mortality from all causes in the lowest socioeconomic group was 29% higher than in the highest socioeconomic group in 2009–2011 (639 and 495 per 100,000 population, respectively) (Table 5.1.3).
- Lung cancer death rates were 1.6 times as high in the lowest socioeconomic group.
- Rates of potentially avoidable deaths—premature deaths that could have been avoided in the presence of timely and effective health care—were 1.8 times as high in the lowest socioeconomic group, compared with the highest (194 compared with 105 per 100,000 population).
- In terms of excess deaths and population impact, if all Australians had the same death rates as the 20% of Australians in the highest socioeconomic group, there would have been 54,214 fewer deaths in 2009–2011.

Table 5.1.3: Inequalities in leading causes of death

	Year	Lowest socioeconomic group (per 100,000)	Highest socioeconomic group (per 100,000)	Rate ratio: lowest/highest socioeconomic group
Coronary heart disease	2009–2011	98	71	**1.4**
Cerebrovascular diseases	2009–2011	46	42	**1.1**
Dementia and Alzheimer disease	2009–2011	32	34	**0.9**
Lung cancer	2009–2011	40	25	**1.6**
Chronic obstructive pulmonary disease	2009–2011	27	16	**1.7**
All causes	2009–2011	639	495	**1.3**
Potentially avoidable deaths	2009–2011	194	105	**1.8**

Source: AIHW 2014d.

What is missing from the picture?

Ongoing work is needed to monitor progress in closing health gaps between socioeconomic groups. Most health data collections in Australia do not include information to measure an individual's socioeconomic position. The use of an area-based measure such as the IRSD limits the extent of analysis regarding the relationship between socioeconomic position and health.

Statistical linkage of health and welfare data sets to provide added information on wealth, education, employment and other social determinants will assist in better understanding pathways through the health system and the relationships between risk factors, disease, service use and outcomes for all socioeconomic groups.

Where do I go for more information?

Many reports from the AIHW include analysis of health indicators based on socioeconomic position (for example, *Mortality inequalities in Australia 2009–2011*).

For more information about disadvantage and social inequalities, see the AIHW report *Australia's welfare 2015*.

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