



SA: THE HEAPS UNFAIR STATE

WHY HAVE HEALTH
INEQUITIES
INCREASED IN SOUTH
AUSTRALIA AND HOW
CAN THIS TREND BE
REVERSED?

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FOREWORD

In 2008, I delivered the final report of the World Health Organization's Commission on the Social Determinants of Health which I had chaired. In our report, the Commission called for global action on the social determinants of health to achieve health equity. The key insight we presented was that the conditions of daily life, in which people are born, grow, live, work and age, and the inequities of power, money and resources, are responsible for health inequities around the world. Therefore, action to improve health equity has to involve all sectors of government and society. Our view was always that where health inequalities can be avoided by reasonable means, they should be. Addressing health inequities is a matter of social justice.

SA: The Heaps Unfair State has been produced by the Southgate Institute for Health, Society and Equity and the South Australian Council of Social Service. It provides the evidence for a concerning growth in inequities in the state of South Australia since the 1980s. It details an explanation for why this has happened and what can be done to change it. I was alarmed when I read this report, which tells a sorry tale of how easily a region that has done comparatively well in reducing inequities in the past can slide backwards as a result of a confluence of factors that affect the health and wellbeing of the community, particularly those in the most disadvantaged situations.

We know what works to make a difference and ensure that we can achieve a fairer distribution of health. This is not new. Where external factors such as global, political and economic trends place greater stresses on a local community, our policy responses need to shore up protections for the whole community, in particular the most disadvantaged. The story told in *SA: The Heaps Unfair State* shows very clearly the consequences of these protections being undermined.

While we can't necessarily control global impacts, we can respond with policies and actions that will make a difference. When the Commission on the Social Determinants of Health released our final report, we argued that it is possible to close the health gap in a generation, and we made recommendations for how this could be achieved through working together to address the social determinants of health. *SA: The Heaps Unfair State* shows that we cannot be complacent. While it is possible to close the health gap, it can also widen. It is important to understand why and how this can happen, and to sustain policy and actions on the social determinants of health to continue to seek a fairer distribution of health in our society.

Professor Sir Michael Marmot

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WELCOME TO THE REPORT

We are very pleased to introduce this report which has been a joint venture between the Southgate Institute for Health, Society and Equity at Flinders University and the South Australian Council of Social Service. We were both alarmed to see the data which show that while life expectancy continues to increase in South Australia, the gradient in health is getting steeper and the health of the least well-off is worsening. We were also worried to see that South Australia was faring particularly poorly compared to other states. Our alarm led us to seek funding for an examination of the reasons for these increases in health inequities.

We won funding from the Flinders University Innovation Partnership Seed grant which has enabled a rapid assessment of why health inequities are increasing. We have done this by compiling the evidence on the social determinants of health in South Australia, by consulting with senior policy actors from a range of sectors who have long experience in South Australia, and through an interactive workshop using the world café format to examine and debate our emerging ideas.

Our study has produced a comprehensive report on ways the disease profile and social and economic status of the state has changed. This report, *SA: The Heaps Unfair State – The Statistical Report*, is available here:

<https://www.flinders.edu.au/content/dam/documents/research/southgate-institute/sa-heaps-unfair-state.pdf>.

This report summarises the key trends that appear to be contributing to health inequities in our state. They concern the impact of the global adoption of policies that increasingly monetise and marketise all aspects of economic and civil life: the decline of South Australia's manufacturing base, the retreat from policies that see the state as having primary responsibility for the welfare and wellbeing of citizens, the increase in casual and insecure employment, a stagnation of wages and increase in wealth inequities, increasing energy costs, and the privatisation of key public services, especially of public housing and disability services. Further crucial changes were identified, such as the politicisation of the public service, a decline of specific policy expertise in the public service and less consultative policy development processes. Finally, our work has identified that much more store is put on economic efficiency and much less on developing community solidarity and on achieving social justice as a policy goal.

We hope that our report will be widely read and discussed in political, bureaucratic, academic and community settings. Our recommendations are made in the hope that they will inform a determination to make South Australia heaps more equal!

Professor Fran Baum

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SOUTH AUSTRALIAN COUNCIL OF SOCIAL SERVICE

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EXECUTIVE SUMMARY

The research findings in this report highlight the growth in health inequities in South Australia since the mid-1980s. The report examines the consequences of a perfect storm of challenging global, national and state factors on South Australia over the past 30-40 years that have resulted in South Australia's increasing health inequities despite continued increases in life expectancy.

During this period from the late 1980s to the mid-2010s, health outcomes have generally improved: life expectancy has increased, and mortality has decreased. However, inequalities in health outcomes according to socioeconomic status have increased dramatically.

This is best captured in the premature mortality rates (see Figure 2.1 in the report). The figure demonstrates a gradient in health whereby mortality differs according to socioeconomic status. A flat gradient suggests a more equal society, where a steep gradient suggests greater inequalities. The gradient of health inequalities in South Australia has been getting steeper over the past few decades. This is reflected in a higher inequality ratio, rising from 1.55 in 1987-1991, to 2.10 in 2011-2015, meaning that the rate of premature deaths in the most socioeconomically disadvantaged areas of South Australia is over twice the rate of premature mortality in its most socioeconomically advantaged areas.

Similar to premature mortality, there have been overall improvements in health outcomes, but worsening health inequalities in South Australia, for:

- deaths from avoidable causes (including deaths by chronic obstructive pulmonary disease, respiratory system diseases, cerebrovascular diseases, ischaemic heart disease, circulatory system diseases, and diabetes)
- infant and child deaths and
- self-assessed health.

South Australia's health inequities are growing faster than other states and territories.

Inequalities have increased in all states and territories, but at different rates (see Table 2.1 in the report). South Australia ranks second worst in terms of greatest increase in inequality ratio. While South Australia was the state/territory with the 4th highest level of equality in 1997-2001, with an inequality ratio below the national average, this dropped to a ranking of 6th in 2011-2015, with an inequality ratio above the national average.

The key themes that have emerged from the research as drivers of inequities in South Australia include:

Impact of de-industrialisation on the South Australian economy and manufacturing industries, and trends in employment and income (including social security income).

South Australia's economy, industry and employment have been hard hit by the global manufacturing shift from high to low- and middle-income countries since the 1970s and the global economic shocks over the same period. Notably, trends in employment and income over this time include:

- the decrease in Manufacturing industry jobs and growth in the Health Care and Social Assistance industry in South Australia.

- the overall rise in employment in South Australia, coupled with its uneven distribution.
- underemployment and underutilisation rates.
- the increase in part time and casual employment.
- the stagnation of income and persistence of wealth and income inequities.
- the freezing of Newstart Allowance since 1994 and its contribution to a progressive deepening of poverty for people in households relying mainly on that payment.

The impacts have been hardest felt by low income workers, those reliant on social security payments and their families, especially youth, Aboriginal and Torres Strait Islanders, those re-entering the workforce and single parents.

Privatisation in education, health, public infrastructure and housing sectors.

Since the early 1980s, economic rationalist policies have been dominant in Australia, and lead to the privatisation of key government services. The privatisation of public housing stock, the growth in private schools, and the growth of the private health and social service sector, including employment services and private health insurance, were highlighted as increasing health inequalities in the state.

Decrease in public housing stock and quality, and increase in housing and living costs.

South Australia has historically spent more on public housing than other states and territories. The decrease in public housing stock and its quality between 1986 and 2016 has most drastically affected the most disadvantaged areas of South Australia. This, in combination with decreasing housing affordability and rising living costs including energy, was noted as entrenching poverty. The rate of household poverty rose from 10 per cent to 23.3 per cent between 1981-82 and 1997-98.

The politicisation and hollowing out of the state and federal public sector's capacity and expertise to respond to economic and social challenges.

The public sector across Australia from the 1980s has been influenced by New Public Management philosophy which focused on commercialisation, decentralisation of public services, corporatisation, contractualisation, marketisation, outsourcing and privatisation, and the creation of a contracted senior executive service. Interviews highlighted the impacts this has had on South Australia's public sector resulting in:

- an increasingly politicised public service.
- the undervaluing of public sector policy roles and the narrowing of policy processes.
- a shift away from addressing health equity, undermining the success of a number of reforms intended to break down departmental silos within government and to encourage intersectoral collaborations.
- a loss of vision in the public sector, policy development and implementation expertise and its capacity to respond to South Australia's circumstances and growing inequities.

The erosion of democratic social justice values and disinvestment in community-based approaches to health and education.

The local and global trend towards individualism has manifested in South Australia in a number of ways:

- the weakening of the welfare state as social security policies become more targeted and the processes to receive payments dehumanising.
- a shift to individual responsibility over state responsibility approaches in health and social public policies.
- a rise in consumerism.
- the funding criteria and competition between NGOs, community organisations and for-profit providers leading to erosion of collaboration, undervaluing of local knowledge and governance, a growth in larger entities better positioned and resourced to participate in market processes, and a reduction in the ability of organisations to respond to community needs.
- loss of health and education movements embedded and present in local communities.

These trends are discussed in more detail within this report.

RECOMMENDATIONS

The recommendations have been divided into sectors, and state and federal government responsibility has been identified. Not all recommendations fall neatly into one sector.¹

Overarching recommendations for the South Australian government

- The South Australian government creates a long-term plan for the social and economic development of the state which will work towards ecological sustainability and human wellbeing and equity, and will do this with full consultation with the community and stakeholders.
- The South Australian government to commit to maintaining and building an adequate state tax base to fund services and reduce reliance on distribution from the GST pool.
- The South Australian government ends budgeted departmental targets, or efficiency dividends, which result in service funding and quality being progressively whittled away over time. Because these service funding cuts are considered to be smaller administrative issues they occur without proper parliamentary scrutiny. Rather than continuing to apply budgeted departmental targets, we recommend that for greater transparency and accountability, and for funding certainty, any funding cuts are made by the Minister and announced in the State Budget.

South Australian Public Service

- Restore and protect the apolitical and independent role of the South Australian public service to ensure it can provide evidence-based advice on complex and challenging issues and pressures faced by the state.
- Review all privatisation proposals through a health and equity lens, and also conduct retrospective health and equity impact studies on areas privatised and outsourced from the 1990s.

Health Sector

- The South Australian Government, led by Wellbeing SA, develop a state-wide **health equity monitoring system and policy** which explicitly addresses the whole-of-government actions needed to reverse the trend and reduce the inequities.
- Increase investment in critical areas, including investment in early childhood development and targeted funding to specific groups, including funding for Aboriginal and Torres Strait Islander Community Controlled Health Services (**federal government**).
- Expand the South Australian Health in All Policies initiative to enhance intersectoral collaboration to address the social determinants of health, and increase the focus of SA Health in all Policies on improving health equity (**state government**).

¹ These recommendations intentionally focus on the social determinations of health, but recognise that within each recommendation specific attention should be paid to the issues facing Aboriginal and Torres Strait Islander people, including efforts made to achieving self-determination.

Digital Inclusion

- Enact strategies to improve digital inclusion in South Australia, through initiatives to support affordability of technology (e.g. smartphones, PCs) and internet connections (mobile and/or terrestrial), good quality internet infrastructure, building people's skills and confidence to use technology and navigate online services, as well as ensuring that alternatives to digital avenues are provided for education, health care and other government services (**state government**).

Housing Sector

- Stop the diminishing of public housing stock, increase the investment in public housing and ensure the maintenance and upgrade of existing stock (**state government**).
- Introduce a green housing infrastructure program, including for public housing, to improve housing and energy affordability, provide employment opportunities and address climate change (**state and federal government**).
- All new housing to be built to the highest energy standard and using universal design principles. e.g. The Nationwide House Energy Rating Scheme (NatHERS) energy rating of around 7 stars² (**state government**).

Employment Sector

- Increase minimum wages for low income earners to improve living standards (**federal government**).
- Acknowledge the challenges of workforce participation and remove the current link between employment support services and the income support system (**federal government**).
- Review the outsourcing of employment services, including consideration of re-establishing a publicly managed and delivered service, and extend who is eligible to use the services (**federal government**).
- Develop tailored employment and pre-employment policies and programs for entry level positions and transitions (**federal and state government**).

Education Sector

- Increase support for public education, particularly schools in areas of disadvantage, reduce subsidies to the private school sector, and target areas of underperformance (**state and federal government**).
- Prioritise and increase investment in universal early childhood care and public primary schools as this will improve the education and health outcomes of all children and

² For more information on 7 Star energy efficient house design <http://www.nathers.gov.au/owners-and-builders/7-star-house-plans>

specifically children from lower socioeconomic backgrounds (**state and federal government**).

Energy Sector

- Ensure that low income households, renters and people living in vulnerable circumstances are prioritised and considered in any government policy that targets interventions occurring with the energy transition in South Australia (**state and federal government**).
- Implement building code regulations that apply to new and existing houses to improve housing stock with retrofits such as insulation and double glazing to reduce electricity costs and ensure comfort in summer and winter (**state government**).
- Ensure that South Australia's strong targets on renewable energy are expanded to other key areas impacting climate and mobility including public transport options, vehicle use and the agricultural industry (**federal and state government**).

Social Security Sector

- Index all social security payments to the average wage index (AWI) at a minimum and ensure they maintain pace with community living standards (**federal government**).
- Raise Newstart, Youth Allowance and other social security payments to reduce poverty and health inequities. This will have a direct impact on people's access to health and wellbeing, improving resources as well as stimulating the economy (**federal government**).
- Support a Single Parent Supplement benchmarked to the cost of children as they age (**federal government**).
- Abolish Compulsory Income Management, the compulsory element of the ParentsNext program, and the compulsory Cashless Debit Card (**federal government**).

Economy and Fiscal Sector

- Adopt a Green New Deal³ to safeguard South Australia in the light of the climate crisis and to provide new job opportunities (**state government**).
- Introduce the concept of a Wellness Budget and draw on the experience of Scotland, Iceland and New Zealand in doing so (**state and federal government**).
- Adopt alternative measures of South Australia's progress (e.g. the Genuine Progress Indicator rather than GDP) (**state and federal government**).
- Invest in the opportunities for economic development that could flow from rapidly advancing technological digital advancements, advanced manufacturing industries, and training institutions to improve economic and employment opportunities in Australia and

³ A Green New Deal (GND) aims to address climate change and economic inequality. This approach was founded in the US in the 2000s and has increasingly gained international support. An Australian Green New Deal could include a suite of environmentally responsible projects which also have a strong business case, such as renewable energy creation, sustainable farming and improved water infrastructure.

South Australia and use innovative mechanisms to link universities with emerging industries **(state and federal government)**.

- Infrastructure SA should consider the development of social as well as physical infrastructure (e.g. community development and healthy urban design) as a key feature of any future plan. **(state government)**.

Rural and Regional

- The SA Infrastructure Plan must include plans for regional and rural areas of South Australia beyond the installation of new needed infrastructure with the aim of thriving, rather than surviving. This includes securing long term regional and rural development owned by the community, and building local economies and capacity of residents **(state government)**.
- Develop new industries based on renewable energy, digital technologies and advanced manufacturing by extending existing initiatives **(federal and state government)**.

Community and NGO sector

- Increase the availability of vital community services that address issues of equity and disadvantage, as well as the pool of funding that is available to respond to new, growing or established community development needs **(state and federal government)**.
- Establish a set of values in all government contracts that recognise the unique contribution of not-for-profits/NGOs in providing economic value, advocacy and community development **(state and federal government)**.
- Ensure all government contracts guarantee good employment conditions, and provide for adequate staff development, research, evaluation, and policy development **(state and federal government)**.
- Provide resources to enable SACOSS to establish a long-term plan for the community and NGO sector in South Australia that incorporates workforce development, and considers what the South Australian community sector should look like and how it differs from and complements the public sector.

1. Introduction

We reaffirm that health inequities within and between countries are politically, socially and economically unacceptable, as well as unfair and largely avoidable, and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security. (Rio Political Declaration on the Social Determinants of Health, WHO, 2011)¹

Australia is one of the most economically advantaged countries in the world, and we are living in one of the most prosperous times in history. Life expectancy is increasing for all population groups, but average incomes are stagnating. The central concern in this report is that in South Australia, the distribution of health across its population has become less equal in recent decades. South Australia is one of eight jurisdictions making up the Australian Federation. It is in the central southern area of the Australian continent. It was occupied for thousands of years by Aboriginal nations with approximately 43 groups in the South Australian region.² White settlement began in 1834 and, unlike other states, South Australia was never a penal colony. In the nineteenth century, South Australia attracted non-conformist settlers and by the mid-twentieth century was building wealth on the back of a thriving agriculture and manufacturing base. In the 1950s, the conservative state government funded state public housing and developed the South Australian Housing Trust to provide cheap housing. This good supply of affordable housing made South Australia an attractive place for manufacturers as it allowed relatively low wages. Major automobile manufacturers were attracted to the state as well as the manufacturers of domestic electrical goods. This manufacturing industry, combined with a thriving agriculture industry, meant that the state was relatively prosperous through most of the 20th century.

Such developments laid the basis for Australia to become and remain one of the richest countries in the world. In 2018, the median wealth per adult in Australia reached the highest in the world³. Yet the benefits of this wealth are not spread evenly in the population. Wealth and income inequality have been increasing in recent decades, reversing a trend of declining inequality from the time of the First World War (1918 onwards) until the early 1980s. Since 2000, the top 1 per cent of global wealth holders owned 47.1 per cent of all household wealth³, and over the last 30 years the growth in the incomes of the bottom 50 per cent has been zero, whereas incomes from the top 1 per cent have grown 300 per cent.⁴ This trend is common in many high income countries, as documented by the economist Piketty.⁵ Wealth inequality in 2018, measured by the Gini coefficient in net worth, was at its highest level in Australia since 1993-94.⁶ The top 1 per cent owned 22.4 per cent of all wealth in Australia in 2018.³

Unsurprisingly, in the wake of these growing economic inequities, health inequalities are increasing. The Public Health Information and Development Unit (<http://phidu.torrens.edu.au/>) documents these increases in inequities and the companion report to this one, *SA: The Heaps Unfair State – The Statistical Report*, details the significant changes to the social and economic make-up of the population (see Box 1.1).

The social and economic factors which shape our health have been shown in numerous studies and reports to be the most significant group of causative factors that determine how healthy a population is.⁷⁻⁹ Explaining why one population, state or nation, is healthier than another primarily requires attention to these social determinants. Access to health care is but one of these. Much more significant is employment, education, housing, energy supply, income and wealth distribution, and social support. These factors determine how health is distributed in a population. Some health inequalities may be a result of factors that can't be altered, such as genetic factors. But many more can be changed, and those that can are referred to as health inequities and are primarily a reflection of how the social determinants of health are distributed.

Box 1.1: SA: The Heaps Unfair State -The Statistical Report

The companion report, *The Heaps Unfair State – The Statistical Report*, draws on publicly available data on health and health inequalities in Australia and data on the social determinants of health to provide quantitative examination of potential underlying factors that might explain the increase in socio-economic health inequalities in South Australia between the late 1980s and the period 2011-2015. It covers:

Health Status

Premature mortality and avoidable deaths

- Changes in inequalities
- Infant and child death rates
- Self-assessed health
- Incidence of disease
- Median age at death
- Inequalities in premature mortality and avoidable Deaths by cause

Social determinants of health

Income

- Poverty
- Income
- Expenditure
- Groups in vulnerable circumstances

Housing

- Public housing
- Rental stress
- Home ownership and affordability

Education

- Participation in school
- Socioeconomic status and participation in school
- Learning or earning among 15- to 19-year-olds
- Post-school qualifications
- Literacy
- Interactions between education and employment

Employment

- Unemployment and labour force participation
- Characteristics of employment

Social exclusion

Access to health care

Other indicators

The period since the Second World War has seen Australia moving to second position in league tables of national life expectancy. This achievement has been built on the back of significant social and economic reform. Many expect that our pattern of increasing life expectancy will continue. Yet improvement is slowing and in the United States and the United Kingdom life expectancy is declining for some groups.¹⁰ This may be a warning bell for Australia, and the increase in health inequities may be an indicator of possible overall worsening economic conditions.

Box 1.2: Differences between inequalities and inequities

Much of the literature on health differentials uses the terms 'equity' and 'equality' interchangeably, but their different meanings have implications for policy action: equality is concerned with sameness; equity with fairness. Policies are unlikely to be able to make people the same, but they can ensure fair treatment. The Commission on Social Determinants of Health defined health inequity as 'Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity'⁷ Baum (2016: 308).⁹

1.1 Why inequities matter

Wilkinson and Pickett's¹¹ research has become very well known for pointing out that less equal societies are also those that are less successful on a variety of measures. This is shown in Figure 1.1, which shows the distribution of an index of health and social problems (listed adjacent to the Figure) by the Gini coefficient measuring how equally income is distributed. It indicates how higher levels of income inequality are associated with greater rates of health and social problems.

We have seen life expectancy drop in the United States, a country that experiences very high rates of inequities (as shown in the graph above) for three consecutive years.¹² It is very possible that if we do not act on inequities in Australia, our uninterrupted growth in life expectancy may also turn around and begin to decrease.

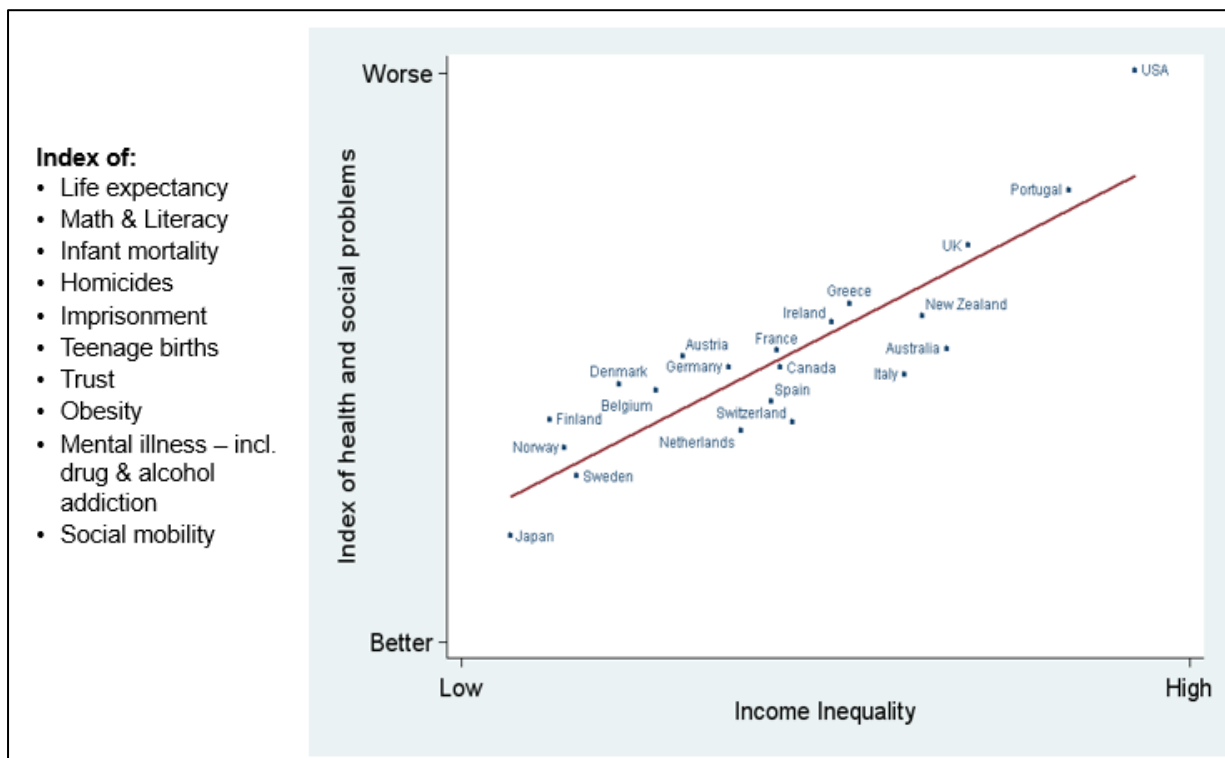


Figure 1.1: Health and Social Problems are worse in more unequal countries (Wilkinson and Pickett 2009).¹¹

1.2 Our research

This pilot research is part of a broader initiative being led by researchers at the Southgate Institute for Health, Society and Equity, called the Punching Above their Weight (PAW) Network (<https://www.flinders.edu.au/southgate-institute-health-society-equity/punching-above-weight-network>). This network was formed to advance thinking and research about why some countries do much better or much worse in terms of life expectancy than would be predicted by their economic status. It builds on previous research that has focused primarily on health sector performance, examining more closely the political, social, environmental and economic processes that drive good or poor performance in promoting population health and health equity. Our network is interested in investigating why South Australia has performed poorly in terms of health equity and so our local research will also provide a case study for international consideration. This research has enabled us to test methods to be used in a planned international study of countries punching above and below their weight.

The framework developed by the PAW network has been used and slightly adapted to frame the South Australian research (Figure 1.2). This figure emphasises the importance of social and economic factors in determining population health and health equity outcomes. In this regard we draw on the work of the Commission on the Social Determinants of Health (2008)⁷ and subsequent work of others.^{10,13}

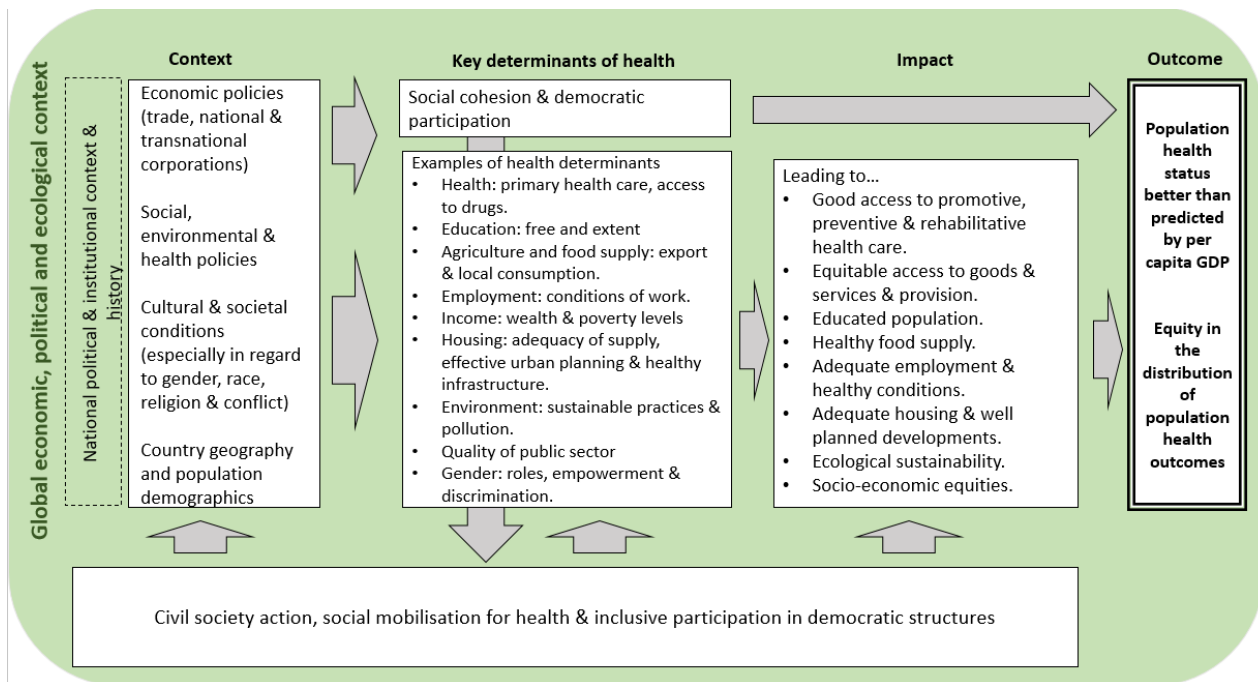


Figure 1.2: Framework to investigate why some countries punch above their weight in terms of health and health equity (Adapted from: Baum et al, 2018)¹⁴

The statistical data collection and analysis laid the foundation for the sectors we focused on in the qualitative data collection (see Box 1.1), including in the health, housing, education, employment, social security and community sectors.

Our research has involved three activities:

1. Compiling the data on health inequities and the social and economic determinants of health which drive health status.
2. Interviewing people with long-term experience working in South Australia in positions that were concerned with advancing health and wellbeing. In total, 12 people were interviewed who had significant experience of public policy in Australia, including current and former senior state and federal public servants, a politician, academics, and policy advocates in NGOs.
3. An interactive workshop was held in September 2019 at which our emerging research findings were debated and our initial recommendations refined and revised in light of the workshop considerations. The workshop was attended by 50 representatives from the South Australian government, policy makers, NGOs, community members and academics.

1.3 Report Structure

This report starts by presenting the health inequality data. It then considers the macro-economic changes that have occurred in the world in our period of interest (from the late 1980s to the mid-2010s), followed by an examination of key themes that have emerged during our analysis, including an assessment of the South Australian economy, the impact of de-industrialisation, and trends in employment and income. The next major trend examined is towards privatisation in education, health and housing. We then describe the declining capacity of the public sector to respond to

challenges, and why South Australia has faced particular headwinds, and finally consider a trend towards a withdrawal from community towards individualism.

2. Health Inequality Data

This report draws on publicly available data on health and health inequalities in Australia and on the social determinants of health. The primary source used to measure inequalities is the Social Health Atlas developed by the Public Health Information Development Unit (PHIDU), which has compiled current and historical data at national, regional and small area levels for Australia from sources including the Australian Bureau of Statistics, the Department of Health, and the Australian Institute of Health and Welfare.¹⁵ These data have been supplemented by publicly available ABS publications, the census, and relevant reports published by government and non-government organisations. A full copy of the data we compiled is available in *SA: The Heaps Unfair State – The Statistical Report*.

While the dates for which data are available vary, we are mainly focusing on the period from the late 1980s to the mid-2010s.

During this period, health outcomes have generally improved; life expectancy has increased, and mortality has decreased.

The increase in socioeconomic inequalities in health outcomes is best captured in the premature mortality rates (see Figure 2.1).

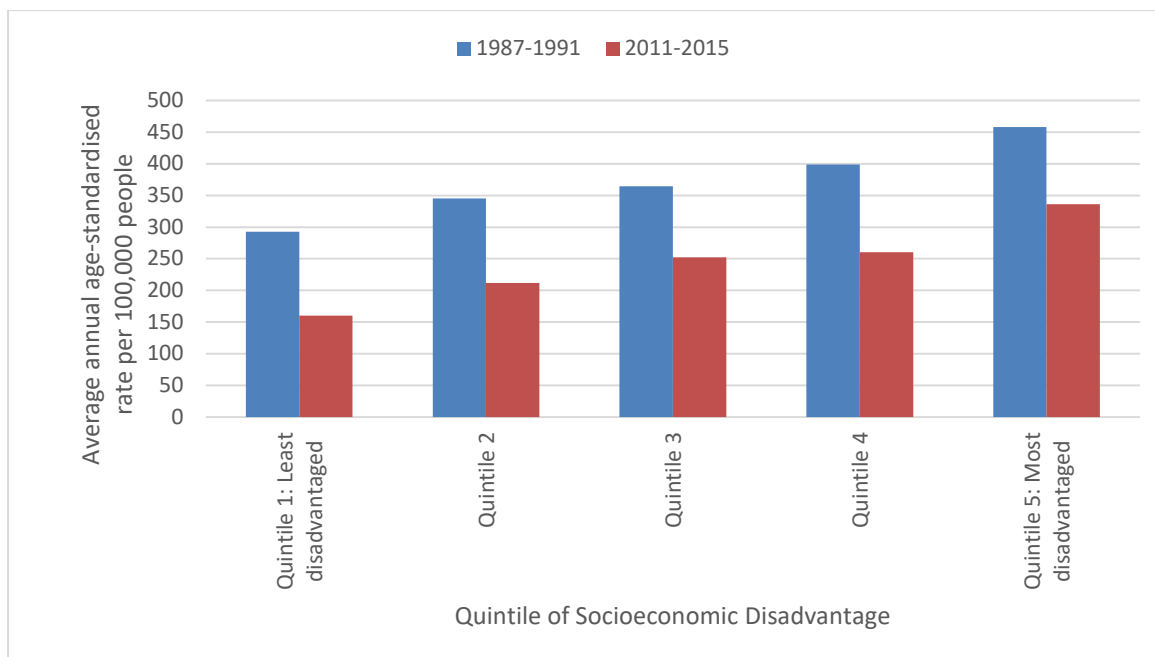


Figure 2.1: Rates of Premature Mortality in South Australia, ages 0 to 74, by quintile of socioeconomic disadvantage of geographic area in which the cohort live, 1987-1991, and 2011 to 2015 (Social Health Atlas, PHIDU, 2018)

The figure demonstrates a gradient in health whereby mortality differs according to socioeconomic status. A flat gradient suggests a more equal society, where a steep gradient suggests great inequalities. The gradient of health inequalities in South Australia has been becoming steeper over the past decades.

Socioeconomic disadvantage is primarily measured by socioeconomic quintile throughout the report. Socioeconomic status is based on the ABS Index of Relative Socioeconomic Disadvantage for data sourced from PHIDU (see explanatory notes at end of the report).¹⁵ The quintiles represent the socioeconomic status of the area in which the population is living.

Box 2.1 Inequality ratios

Inequality ratios are the primary measure of inequality in the report, and these are the ratio of the rate for the 20 per cent of the population living in the lowest socioeconomic status area to that for the 20 per cent living in the highest socioeconomic status area. For premature mortality, the social gradient has worsened, as represented by a higher inequality ratio (2.10 in 2011-15 compared with 1.55 in 1987-1991). An inequality ratio greater than 1 represents inequality in the case of undesirable outcomes (e.g. premature mortality and avoidable deaths). For example, an inequality ratio of 2.10 for premature mortality means that the rate of premature mortality for quintile 5 is 2.1 times the rate of premature mortality for quintile 1.

Similar to premature mortality, there have been overall improvements in health outcomes, but worsening health inequalities in South Australia, for:

- deaths from avoidable causes (including deaths by chronic obstructive pulmonary disease, respiratory system diseases, cerebrovascular diseases, ischaemic heart disease, circulatory system diseases, and diabetes),
- infant and child deaths, and
- self-assessed health.

2.1 South Australia's health inequalities are growing faster than other states and territories

Inequalities have increased in all states and territories but at different rates (see Table 2.1). South Australia ranks second worst in terms of greatest increase in inequality ratio and in terms of percentage change from the 1997-2001 inequality ratio. South Australia's percentage increase in inequality ratio is well above the national average.

STATE	HEALTH INEQUALITIES RATIO 1997-2001	HEALTH INEQUALITIES RATIO 2011-2015	INCREASE IN INEQUALITY RATIO
New South Wales	1.59	2.11	0.52
Victoria	1.32	1.85	0.53
Queensland	1.58	1.89	0.31
South Australia	1.52	2.18	0.66
Western Australia	1.64	2.26	0.62
Tasmania	1.4	2.03	0.63
Northern Territory	3.5	4.23	0.73
Australian Capital Territory	1.39	1.87	0.48
Australia	1.55	2.06	0.51

Table 2.1: Changes in the Health Inequality Ratio from 1997-2000 to 2011-2015 for Deaths from all Avoidable Causes (Social Health Atlas, PHIDU, 2018)

2.2 Population groups

While this report focuses on socioeconomic disadvantage and drivers of inequities more generally, we note the issues faced by groups who have particular health inequities.

Aboriginal and Torres Strait Islander health inequities

Aboriginal and Torres Strait Islander people experience well documented health inequities arising from historic and ongoing colonisation. Like the rest of Australia, South Australia is on track to reach only a few of the Closing the Gap targets (on early childhood education and completion of Year 12 or equivalent, but not for child mortality, school attendance, life expectancy, reading and numeracy, and employment).¹⁶ Aboriginal and Torres Strait Islander people's self-assessed health is in fact getting worse: in 2002, 21 per cent of South Australian Aboriginal and Torres Strait Islander people were estimated to be in fair or poor self-assessed health, and the figure rose to 27 per cent in 2008 and 2014-15.^{17,18}

Increases in life expectancy for non-Indigenous Australians and Aboriginal and Torres Strait Islander people are shown in Table 2.2 below. There has been modest progress in the closing of the gap in life expectancy for Aboriginal and/or Torres Strait Islander people: from a 13% difference between non-Indigenous and Aboriginal and/or Torres Strait Islander females and 17% difference for males in 2005-2007, to a 10% difference for females and 12% difference for males in 2015-2016.

	2005-2007	2010-2012	2015-2016
Females, non-Indigenous	82.6	83.1	83.4
Males, non-Indigenous	78.7	79.7	80.2
Females, Aboriginal and/or Torres Strait Islander	72.9	73.7	75.6
Males, Aboriginal and/or Torres Strait Islander	67.2	69.1	71.6

Table 2.2. Increases in life expectancy in Australia (AIHW 2019)¹⁹

Despite these overall gains, inequalities in health outcomes between non-Indigenous and Aboriginal and Torres Strait Islander peoples persist.

The ongoing effects of colonisation are evident in the *SA: The Heaps Unfair State – Statistical Data Report*. Imprisonment rates in South Australia have been between 12 and 16 times higher for the Aboriginal population compared with the non-Indigenous population over the period from 2007 to 2015,²⁰ and at least 15 times greater than the rates for non-Indigenous persons over the decade prior to 2003.²¹ In South Australia, the rate of Aboriginal and Torres Strait Islander youth detention ranged from approximately 17 and 32 times the non-Indigenous rate between 2013 and 2017.²² The rate of Aboriginal and Torres Strait Islander children under care and protection orders in South Australia ranged from 6 to 9 times the rate of non-Indigenous children over the same period, and the rate of Aboriginal and Torres Strait Islander children in out-of-home care ranged from 7 to 9 times the rate of non-Indigenous children.²³

Migrant and refugee health inequities

While health outcomes vary between cohorts of migrants, and there are in some contexts a documented 'healthy migrant effect',²⁴ international literature indicates that the health and health service needs of people from migrant and refugee backgrounds are more complex than those native born.²⁴⁻²⁶ In particular, refugees and asylum seekers have worse health outcomes than those

native born, particularly for mental health.^{27,28} Previous Southgate Institute research has documented the health, wellbeing, housing, and resettlement issues faced by people from refugee and asylum-seeking backgrounds when settling in South Australia.²⁹

Gender inequities

While it is well recognised that males have a lower life expectancy than females, there are important gender considerations across many social determinants of health, and determinants may affect males and females in different ways. While the scope of this report does not allow in-depth consideration of these gender considerations, we are cognisant that they do pervade all social determinants of health and are important in addressing health inequities. For example, due to gendered norms about caring responsibilities, women make up a far greater percentage of single parent families and carers, which impacts on employment and income opportunities and puts them and their children at greater risk of poverty.³⁰

Regional and remote health inequities

The health inequities facing people who live in rural and remote areas are well documented. In Australia, people living in more remote areas have a lower median age of death, and higher mortality.³¹ In South Australia, people living in Adelaide have lower premature mortality than those living outside of Adelaide (see Figure 2.2).

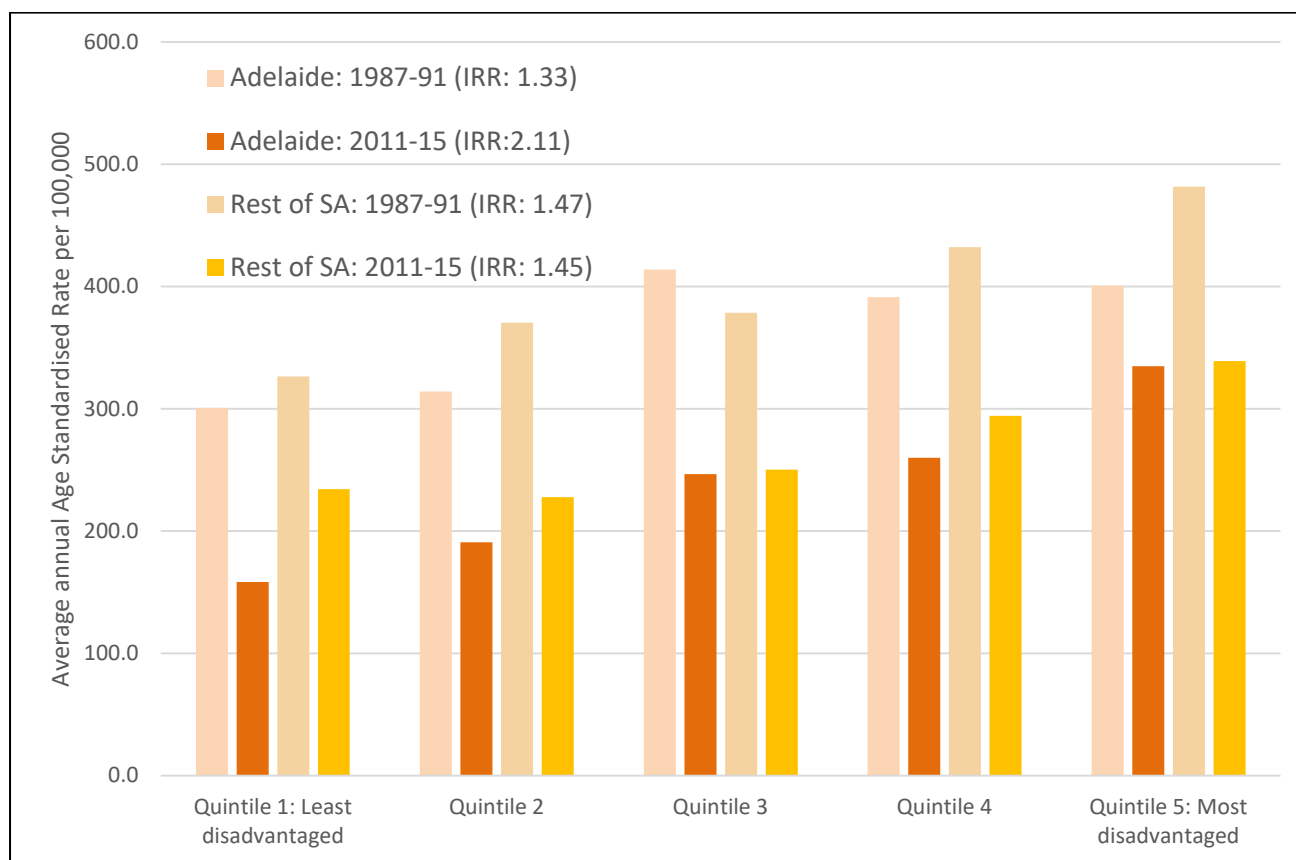


Figure 2.2: Rates of Premature Mortality in South Australia, ages 0 to 74, by quintile of socioeconomic disadvantage of geographic area in which the cohort live, 1987-1991, and 2011-2015, for Adelaide, and the rest of South Australia (Social Health Atlas, PHIDU, 2018)

Figure 2.2 shows that while inequities by socioeconomic area have increased considerably in Adelaide, outside of Adelaide, there has been little change in the health inequity rate ratio between 1987-91 and 2011-15. The reasons for this require further investigation that has not been possible in the confines of this pilot grant.

3. How the world has changed since the 1980s

Along with increasing inequities in wealth and income, what else has changed in the world since the 1980s that has had an effect in South Australia? We have identified 3 key themes that have affected South Australia and are likely to have resulted in increased inequities:

- The global dominance of neo-liberal economics and policies.
- Shift of global manufacturing from high to low- and middle-income countries.
- Retreat from a welfare state to residual social support.

3.1 Neo-liberalism

The most significant change since the early 1980s has been that much of the world has had a love affair with neo-liberal economics. Eleven of our 12 interviewees mentioned this trend as significant. It was seen as resulting in significant changes in the ways in which the state and the market relate to each other. This global trend affected South Australia through changes to the ways in which financial institutions were governed, leading to the State Bank collapse, the opening up of the Australian economy to global trade, the privatisation of key government services, and the growth of economic inequities. In the 21st century, the Global Financial Crisis has led to austerity politics, such as cuts to public services to reduce government budget deficits, which, as one respondent said: “you would expect to impact adversely on health outcomes”.

Trade: One of the most significant areas of change has been the opening up of national economies to competition and the introduction of free trade between nations. Australia was one of the early adopters of this policy from the 1970s. This had implications for South Australian manufacturing industries as discussed below.

Privatisation of previously state-owned assets. The policy of privatisation of key areas of the economy has been advocated by monetary institutions such as the World Bank since the 1980s. Around the world, electricity, water, financial sectors, health care and housing have been privatised and South Australia is no exception. We discuss how privatisation has characterised some sectors in section 5 of this report and its impacts.

Box 3.1 Defining Neo-liberalism

Neo-liberalism is an ideology and policy model that views competition as fundamental to human relations and the market as the mechanism that will most effectively deliver benefits to consumers. It is characterised by policies that support replacing public good with individual responsibility, strong private property rights, free markets, and free trade.³² The policies associated with neo-liberalism have been: lowering of trade barriers; deregulation of the labour market; privatisation or contracting out of public services; the use of the private sector’s management techniques within public sector organisations; low taxation; and policies to reduce state funding for health, education, welfare, housing, arts and public transport.⁹

Neo-liberal ideas and assumptions have become part of everyday language and expectations in Australia.³³ This has meant the extension of free-market ideas into aspects of life that were traditionally governed by non-market norms.³⁴

Changing nature of the public service. This includes changes to the nature of and cutbacks to the public service. These changes appear to have weakened the capacity of the South Australian public service to be innovative and creative in devising new policy directions to meet the considerable headwinds that the state is facing. This issue is discussed in more detail in section 6 of this report.

The financial collapse of South Australia's State Bank in 1991 arose directly from the neo-liberal driven deregulation of the global financial markets, resulting in a lack of state government revenue. McCarthy³⁵ notes that as a result of that deregulation, the bank turned its back on its history as a community bank, adopted a "greed is good" mentality and made a series of risky deals. The majority of interviewees mentioned the adverse impact this has had on the state. It was seen to be an important factor in explaining the increase in inequities:

The State Bank collapse clearly was a major thing that drove privatisation and contracting out in that '90's period. The closure of, but I think the big story really here is, an intellectual story about the rise of neo-liberalism and the collapse of social democracy. (Public policy academic)

For some respondents, the shift towards market economics came with a reduction in public policy concern about inequities, a hardening of attitudes towards people and a celebration of wealth. A typical comment was:

Along with the shift in thinking about economics, a shift in terms of attitudes to poor, I just think that the public discourse has actively moved away from any discussion of class, of inequality. We have moved from welfare, for example, as being social responsibility, you know, community responsibility and a right for people, through to being something for whom there is this big obligation, through to being a privilege. (NGO sector expert)

The era of marketisation and economic rationalisation has seen a growth in wealth and income inequality in Australia. The privileging of capital under neo-liberalism has meant that those who own capital have been able to increase their share and so widen inequities.

3.2 Shift of global manufacturing from high to low- and middle-income countries

The impact of neo-liberal reforms, including tariff reduction, was to have a particularly dramatic effect on the shape of the South Australian economy. The loss of protection for manufacturing industries and the rapid development of such industries in many low- and middle-income countries had a big impact on the South Australian economy. Since 1990, South Australia has lost around 30,000 manufacturing jobs. At the start of our period, South Australia was the home to two major car manufacturing plants: Mitsubishi in the south of the city, and Holden in the north. By 2019, both of these plants had closed. This is further explored in section 4. Here we note that the loss of these plants appears to have resulted in a loss of confidence for the state and much soul searching about which sectors might provide replacement jobs.

3.3 The state's role in the provision of welfare

Part of the retreat from social democracy described by some respondents was a general retreat from the state's role in the provision of welfare in many western democratic countries. While in Australia this trend hasn't been so evident, there has been a retreat from the development of innovative services which were a hallmark of South Australia in the 1970s and 1980s. In South Australia, those decades saw a period of reform of and innovation in social and health services. One respondent noted:

There was a genuine interest in innovating new sets of relationships, new ways of organising a community. There was a strong tradition of community development in place and people were seeing where there was social services effort that their job was to actually work closely with community to build the things that they were interested in. (Social services expert)

This spirit of innovation had led to many reforms in prisons and welfare services, services to people with disability, women's health services, and the development of community health centres and Aboriginal community-controlled health services. All these developments are documented in the edited collection by Baum, *Health for All: The South Australian Experience*.³⁶ The importance of these reforms in contributing to the period of greater equity in the 1970s until the mid-1990s is detailed in other parts of this report.

In the past two decades, most income support payments, in particular Newstart, have not increased (with the exception of the age and disability pensions). This is likely to have contributed to an increase in inequities. Poverty affects health in many ways. People cannot afford to buy medication or heat or cool their houses, or pay rent. Our analysis of data on the shape of inequities in South Australia indicates that those in the bottom quintile are doing particularly badly. This is shown in terms of educational outcomes, employment and housing insecurity. These trends in the context of a weakening welfare state are extremely bad for population health and health equity. The nature of these trends in South Australia is described in the following section.

4. A toxic mix: Deindustrialisation, structural changes to employment opportunities, and unequal incomes

The restructuring and deindustrialisation of the Australian economy that has occurred since the 1980s has been identified in this study as a major contributing factor for an increasing number of South Australians experiencing economic and social exclusion.

The evidence gathered from this study suggests the South Australian economy has been more vulnerable than the economies of other Australian states to the negative consequences of a globalised market economy and neo-liberal economic policies, including the effects of global and national recessions, labour market restructuring and government austerity measures. Interviewees repeated a similar narrative: that with a relatively small economy and population compared to other states, South Australia has been less likely to withstand economic shocks and downturns, which have adversely impacted low income and unemployed people and their families. Dean³⁷ points to the failure of fiscal and employment policies in South Australia to adequately invest in innovation and diversification of industries to adapt to the changing labour market. At the same time, industrial protections and conditions have been eroded and employment has become more insecure for a growing number of South Australians.

One positive aspect concerning employment and adaption to deindustrialisation is the growth of renewable energy initiatives by the South Australian government. These include the \$150 million offered under the Renewable Technology Fund and growth of the renewable energy industry in South Australia which has the potential to reduce inequity in this state through increased employment and lower electricity costs. However, the energy transition requires additional attention to equity. South Australia generated approximately 51 per cent of their energy from wind and solar sources in 2018. South Australia also has the unenviable reputation of having the highest electricity prices in Australia. With ageing grid infrastructure that was initially set up for a centralised power system, the introduction of intermittent sources of energy has required further investment in technologies to manage reliability of the grid, such as batteries. Currently low-income

households rarely install solar Photovoltaic panels to assist them to mitigate the increased cost of electricity because of high upfront costs. In that sense, although deindustrialisation and employment in the renewable energy sector offers opportunities, these need to be balanced with the lived reality of low-income households. Public policies are required to share the benefits of the state's energy transition equally.

4.1 Deindustrialisation and structural changes to industry type

We lowered our tariffs and non-tariff protection much faster than most of [the] other competitive nations ... From a fair trade point of view, it's a foolish thing really, we didn't have to do it as quickly as that. And the harm caused by an overzealous application of neo-liberal trade policy was the decline of manufacturing over that period of time. And the liberal creation of the view that a service economy called the 'new economy' would be superior to that previous model of economic and industry development. But, as we know, the new economy as it unfolded has been characterised by the precarious forms of employment, which is the foundation for growing inequality. (Economist)

The South Australian economy was founded on and continues to be heavily reliant on manufacturing industries.³⁸ The manufacturing industry has historically represented a larger proportion of South Australia's economic output compared with the national average.³⁹ Deindustrialisation of the Australian economy led to the closing down and moving offshore of manufacturing work, which has occurred through a number of waves. These have included: two major South Australian shipbuilding yards closing in the 1970s; closures in textile, clothing and footwear manufacturing; the Port Stanvac Oil Refinery closing in 2003; significant and ongoing cuts to the lead and steel-smelting operations at Port Pirie and Whyalla; and the closures of Australia's car industries (2004-2008 Mitsubishi closure; 2013-2017 Holden closure). Approximately 30,000 manufacturing jobs have been lost in South Australia since the 1990s.

Global recessions in the late 1980s and early 1990s resulted in substantial retrenchments and closures in manufacturing businesses in Australia. Most devastatingly, the South Australian State Bank collapsed in 1991. This resulted in a critical policy shift in South Australia which saw the privatisation of public assets and services to make up for lost revenue (discussed below in section 5). The South Australian Liberal governments (1993-2002) and successive Federal governments allowed markets to determine industry policy which, together with the global trends discussed above, resulted in the decline in manufacturing. The implications have been long-term damage to the South Australian economy, and to the livelihoods of low-income workers and the unemployed.

An interviewee noted that recessions are devastating for people with low educational attainment and on low incomes, as "people lose their jobs and find it very hard to get new jobs, and to get jobs that are anything like the ones that they've lost in terms of pay and status and security."

The changes to the economy have meant the loss of manufacturing jobs in large corporations which offered secure and long-term full-time employment. These have been replaced by a growth in less secure, lower income jobs.⁴⁰ There has been substantial growth in the Health Care and Social Assistance industry which, as of 2016, has grown to become the largest industry in the state in terms of workers (Table 4.1). As one labour market expert explained:

The vulnerability at the lower end of the income spectrum is being manifoldly, I think, reinforced by the quality of jobs that are available and rise in the precariousness that we've seen. And that is very difficult to counter because of the nature of the employment growth that we're experiencing. So, all the growth, nearly all the growth is concentrated in those sectors that generate part-time/casual short term jobs.

Industry type	2006	2011	2016
Health Care and Social Assistance	86,220	100,602	110,479
Retail Trade	81,399	83,070	79,742
Education and Training	52,377	58,637	64,506
Manufacturing	88,489	77,890	59,579
Construction	46,085	55,599	56,635
Public Administration and Safety	44,876	52,263	52,914
Accommodation and Food Services	40,373	46,249	49,738
Professional, Scientific and Technical Services	36,178	40,551	41,499

Table 4.1: Largest industries in terms of workers, South Australia (Census of Population and Housing, ABS, various years)

The communities that these former manufacturing industries were located in are impacted the most by the economic change as seen in other countries such as the UK.⁴¹ An interviewee explained:

The labour market for many factory workers in particular, and households that were exposed to that, exacerbated inequalities in those households concentrated in the north and south of Adelaide. We saw a hundred thousand manufacturing jobs lost nationally, and here in South Australia we saw thirty thousand manufacturing jobs lost and we never recovered from that really. (Labour market expert)

A 2016 study evaluating the impact of retrenchment at Mitsubishi in the south of Adelaide found that many ex-employees struggled to find full-time employment and had to settle for casual or part-time contract positions. Over 30% of respondents to that study were not participating in the workforce 12 months post-redundancy.⁴²

A labour market expert we interviewed noted that while manufacturing is still a major employer in South Australia, the continued lack of interest in investing in sustainable advanced manufacturing, like many other high income nations (e.g. US, Germany and UK)⁴³⁻⁴⁵ have been doing for decades, has led to a number of missed opportunities for employment and business development in South Australia.

4.2 Employment conditions and characteristics

The supplement to this report, the *SA: The Heaps Unfair State – Statistical Data Report*, shows that changes to employment conditions and characteristics have played a central role in the growth in inequalities in South Australia when compared to other states.

Firstly, while unemployment has fallen, the unemployment rate in South Australia is persistently higher than the national average. Youth and Aboriginal and Torres Strait Islander unemployment rates remain much higher than the overall rate. The participation rate for South Australia is consistently lower than the Australian average between 1991 and 2017 (Figure 4.1), and the increase in employment has been distributed unevenly, exacerbating the social gradient in unemployment and income, and contributing to high poverty rates for the disadvantaged.

This is further reflected in the socioeconomic distribution of unemployment in South Australia. The rate of unemployment has fallen for every quintile between 1986 and 2014, but the social gradient has worsened. The inequality ratio of unemployment has increased from 2.53 to 3.25, indicating

that the increase in employment over this period has benefited the most advantaged. The unemployment rate in South Australia has been higher than the Australian average in almost every year from 1991 to 2017. The gap between the unemployment rate in South Australia and Australia widened over two periods: during the 1990s, and between 2013 and 2017.

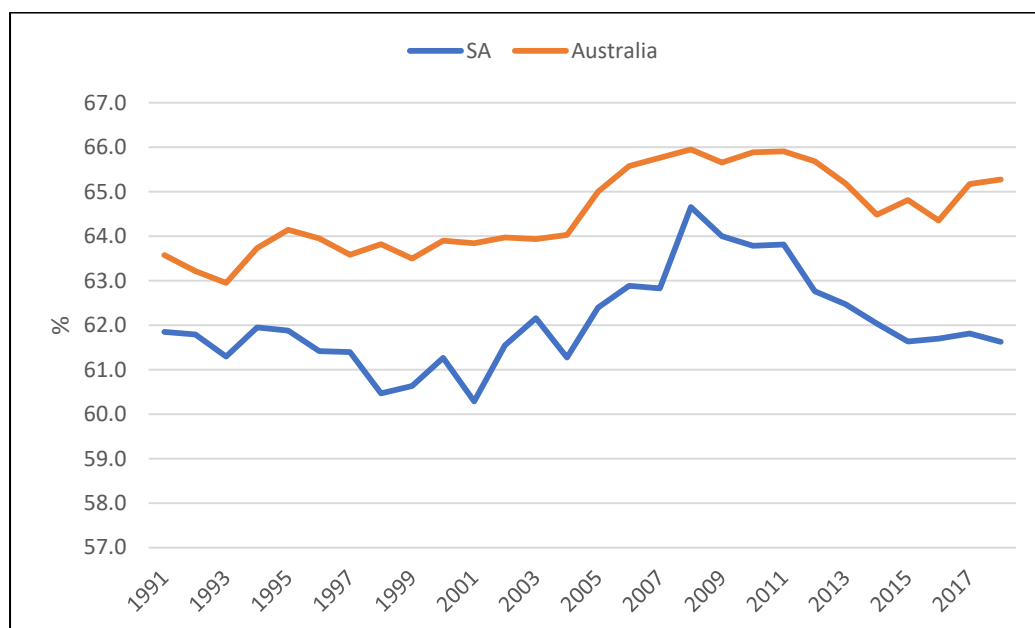


Figure 4.1: Labour force participation rate, South Australia and Australia, 1991 to 2017 (per cent) (Labour Force Australia, ABS, 2018)

There has also been an uneven proportional increase in participation rates, favouring the most advantaged. Labour force participation increased by 3.4 per cent for quintile 1 (most advantaged), compared with a rise of just 0.4 per cent for quintile 5 (least advantaged). Unpacking this further by gender, the rise in the labour force participation rate in South Australia until 2008 was driven by an increase in female labour force participation. For men, the participation rate has fallen from just under 73 per cent in 1991 to just under 67 per cent in 2017, while over the same period, women’s participation increased from 51 per cent to 57 per cent.⁴⁶ It is important to note that the increase in employment over the 1990s was unevenly distributed, and mainly benefited families in which there was already an employed adult.⁴⁷

Underemployment and underutilisation

Employment rose in South Australia from the mid-1980s, but underemployment also increased as evidenced by the underemployment ratio between 1986 and 2018. This ratio increased in South Australia from just over five per cent in 1986 to as high as 11 per cent in 2017.⁴⁶ The underemployment rate in South Australia is consistently higher than the Australian average.

The underutilisation rate adds the unemployed and underemployed together, offering a measure that captures the percentage of the labour force that is underutilised. The underutilisation rate in South Australia has fluctuated, but has remained within the 12 to 15 per cent range since 2000. This follows the national trend, but South Australia has a higher underutilisation rate than the national average, which is unsurprising given that unemployment and underemployment rates in South

Australia exceed the national average. In 2015-16, one in every six workers in South Australia was either unemployed or underemployed.⁴⁶

Increase in part-time and casual employment

Over the last 20, 30 years we have had a collapse of the youth full-time labour market, and that's worked through the economy now, so that we have significant increases in the casualisation of the labour market, and I would say a squeezing of the full-time age demographic. (NGO sector expert)

Full-time and permanent employment was once the norm, with 75 per cent of Australians and 73 per cent of South Australians employed full-time in 1992. Employment grew by 28 per cent between 1992 and 2013 in South Australia, but full-time employment only grew by 15 per cent over the same period.⁴⁸ South Australia has had a persistently lower rate of full-time employment compared to the national average. Part-time employment grew by 65 per cent in South Australia between 1992-2013, more than double the overall growth in employment and four times the rate of growth of full-time employment.⁴⁸ This higher rate of part-time employment contributes to lower incomes in South Australia. It could also explain the state's higher rate of underemployment.

Casual employment increased by 47 per cent in South Australia between 1992 and 2013,⁴⁸ which is higher than the national average over this period. The higher rate of casual employment in South Australia is the result of larger shares of employment in industries that hire higher rates of casuals (e.g. retail, administrative and support services, health care, and social assistance).⁴⁹

Entering and re-entering the workforce: youth and long-term unemployment

If unemployment is rising, the people who suffer most from that are the young people because firms stop employing new people. That's the first thing they do. ... So, the new entrants to the workforce, which includes women who are coming back to work after raising a family, are the ones who suffer first when unemployment goes up. (Labour market expert)

Rates of unemployment and underemployment are higher for some groups than others in South Australia. For example, Aboriginal and Torres Strait Islander unemployment in South Australia was estimated to be 22 per cent in 2014-15, more than three times the overall unemployment rate.¹⁷

A further troubling trend over this period has been young people's higher rates of unemployment. The jobless rate in South Australia for 15-24 year olds rose to as high as 21 per cent in 1992, and was at its lowest in 2007, at nine per cent. Youth unemployment has been double the overall unemployment rate since 2001. Young unemployed people living alone, particularly those reliant on Youth Allowance or Newstart Allowance, live below the poverty line.^{47, 50, 51} In addition, the Productivity Commission's report on rising inequality in Australia reported that young people now have considerably lower incomes than they used to.⁵²

As noted in the quote at the beginning of this section, those re-entering the workforce face similar precarious circumstances, and are also more likely to become long-term unemployed. It was recently reported that a Newstart (now titled 'Jobseeker') recipient is more commonly over the age of 45, a woman, and more likely to live regionally.⁵³ In addition, women and older recipients are more likely to be long-term unemployed; meaning that they are on the payment for longer than a year. Emsilie and Wood⁵³ highlighted a potentially contributing factor: the increase in the number of older people on Newstart has coincided with a sharp decline in the number of older people receiving the Disability Support Pension since 2012 when assessment measures were tightened.

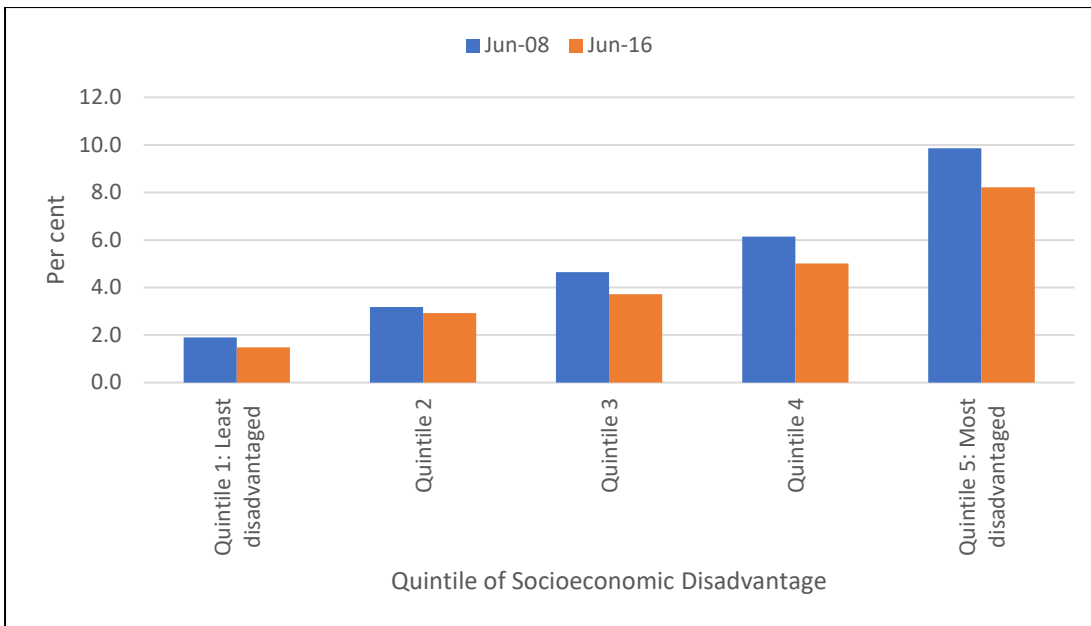


Figure 4.2: Young people aged 16 to 24 receiving an unemployment benefit by quintile of socioeconomic disadvantage of geographic area in which the cohort lives, 2008 and 2016, South Australia (per cent) (Social Health Atlas, PHIDU, 2018)

4.3 Industrial relations policies: increasing the precarious nature of work

Alongside the economic and fiscal policies and restructuring described above, workplace and industrial relations policies from the 1980s have impacted industrial protections and added to the changing working conditions for many Australians.

Historically in Australia, wages have been set on an industry-wide basis. Beginning in the late 1980s under the Labor governments of Hawke and Keating, changes in industrial relations and protections for workers brought in enterprise bargaining. In 1987, the Australian Conciliation and Arbitration Commission sanctioned agreements at the enterprise level, covering issues such as performance-based pay, multiskilling and new shift arrangements. The Australian Industrial Relations Commission, established in 1988, encouraged enterprise-by-enterprise bargaining and individual contracts. The Industrial Relations Reform Act 1993 allowed workplace disputes to be settled by enterprise bargaining between employers and unions in the workplace.

Under the Howard Coalition government, individual bargaining in workplaces was introduced with the Workplace Relations Amendment (Work Choices) Act 2005 (repealed in 2009). These pieces of legislation marked a shift in national policy, placing the responsibility on individual workers and workplaces to negotiate an agreement and improve their position, increasing the precarious nature of work.⁵⁴

4.4 Income stagnation and income and wealth inequality

Incomes have grown in South Australia for all quintiles of equivalised disposable income between 1994-95 and 2015-16, but inequality of income has not improved.⁵⁵ Equivalised (by household composition) household disposable income for the highest quintile was 4.8 times that received by households in the lowest quintile in 2015-16.

Adding to the story of inequity is the fact that income growth in South Australia has not kept pace with growth in expenditure. The poorest households with the lowest disposable income in South Australia experienced the largest percentage increase in total weekly expenditure on goods and services between 2009-10 and 2015-16 (76% increase).⁵⁶ Income growth was stagnant over the same period, for all quintiles.

According to the Productivity Commission ‘about nine per cent of Australians (2.2 million people) experienced relative income poverty (income below 50 per cent of the median) in 2015-16, with children and older people having the highest rates of relative income poverty’ and despite 27 years of uninterrupted growth, this has not declined.⁵²

South Australia is not only a low-income state, it is also a low wealth state, exacerbating its comparative disadvantage. South Australia has the second lowest mean net worth of all states and territories (after Tasmania) and the third lowest median net worth (after Tasmania and the Northern Territory). Mean household net worth for the lowest household quintile in South Australia was estimated to be only \$29,200 in 2015-16, compared with \$1,974,400 for the highest quintile.⁵⁶ Low-wealth households have not experienced any real increase in household net worth in Australia since 2003-04, while the highest quintile increased their share of wealth from 59 per cent in 2003-04 to 63.4 per cent in 2017-18.⁴⁸ The disparity in household net worth in South Australia has not improved between 2003-04 and 2015-16, mirroring the national trend of persistent wealth inequality.⁵⁶ The top 10 per cent owned 52.7 per cent of all wealth in Australia in 2018.³

One NGO interviewee argued that we need to “talk about wealth” in Australia and highlighted how employment conditions and wealth interact, stating that “the casualisation of the labour market has significantly impacted on wealth distribution.”

One factor related to income that may exacerbate inequalities is increasing energy prices in South Australia. In 2017, South Australia had the highest retail prices per kilowatt hour (kWh) in the nation,⁵⁷ and consistently had the highest average annual electricity bills of all states and territories between 2013 and 2017.⁵⁸ South Australia also has the second highest average annual gas bills of all states and territories, with only Queensland having fractionally higher gas bills.⁵⁸ Combining gas and electricity, South Australia has the highest energy bills of all states and territories. Energy bills represented more than 10 per cent of disposable income between 2013 and 2017 for low income households (where they have electricity and gas supply), the highest share of all states and territories with the exception of Victoria.⁵⁸ Adding to this, the increase in expenditure on energy for the lowest quintile of equivalised household disposable income in South Australia was 50 per cent higher than the average increase in expenditure for all households between 1998-99 and 2015-16.⁵⁶ High energy bills increase the likelihood of bill shock and put additional pressure on the budgets of disadvantaged households who are more likely to be facing the challenges and limited opportunities associated with low income.

High energy prices are particularly of concern in relation to poor quality housing. People experiencing socioeconomic disadvantage are more likely to be living in poorer quality, less insulated housing. They are also likely to be renting such housing, which reduces their control over improving the housing quality. Less insulated housing requires more heating and cooling, resulting in very high basic living costs:

People have often asked me what’s the one policy thing you’d do to improve energy affordability and my response will always be have decent housing. I mean, the poorest people in this state are almost all renters and we’re still seeing people spending two thirds of their income on housing plus electricity, so rent plus electricity. So, in terms of basic Maslow principles we’ve got two thirds of your income, add water and gas and

you're probably up to 70 percent of income being spent just on level 1 of Maslow's needs hierarchy. Doesn't leave much for like food, health, exercise, holidays. (NGO sector expert)

Interviewees noted that as well as the public housing stock dwindling, the quality of the remaining stock was decreasing, because they "haven't been maintained properly".

Increased electricity costs in South Australia have been attributed to various factors that include an increase in wholesale electricity prices.⁵⁹ This would appear counterintuitive, given the significant increase in wind energy in South Australia, which actually has the effect of reducing wholesale electricity prices. However, the closure of two coal fired power plants, the Northern Power Station in South Australia and Hazelwood Power Station in Victoria, has led to reduced generation capacity on the National Electricity Market (NEM), particularly in summer when demand for electricity in South Australia is high at peak times. Gas prices have also increased and generation in South Australia on the NEM now mostly consists of gas, wind energy and a significant amount of small scale solar energy.⁶⁰ South Australia also imports electricity from Victoria when additional generation is required and exports electricity when generation from wind exceeds demand in the state. Other factors that are attributed to increasing electricity costs include network expenditure.⁵⁹ South Australia expects further network expenditure in the near future, such as the interconnector from South Australia to New South Wales, in an effort to maintain reliability on an ageing, centralised grid with increasing renewable energy generation.

It was acknowledged that the private sector has led investment in renewable energy, which can be seen as a positive development for the climate. However, as climate change is a global issue and global emissions continue to increase, temperature extremes that affect health and wellbeing for people are unlikely to shift in the short to medium term with South Australia's renewable energy developments.

In South Australia we are world leading in terms of the uptake in solar panels and wind energy. Who is driving that? It's actually business. The business case is sound. So, let's get out the way and leave it to business to basically make the renewable future happen. I never thought I'd be saying that five years ago. (NGO sector expert)

While there has been some political commentary that South Australia's renewable energy sector may have contributed to high energy bills, this has been rebutted,⁵⁹ as wind and solar electricity on the NEM reduce wholesale prices as previously noted. The expansion of renewables technologies, especially solar, in South Australia has been more available to wealthier households who can afford the capital costs and have received generous public subsidies. In addition, low income households are more likely to be in private rental housing where there is less incentive to institute energy saving measures and install renewable energy. The result of both of these trends is that energy inequities have been increased, which in turn will drive health inequities.

4.5 Social security income support: from social responsibility to individual privilege

The interviewees in this study and workshop attendees repeatedly noted the direct negative consequences that low social security payments are having on the health of the poorest Australians, many of whom they see daily in their workplaces.

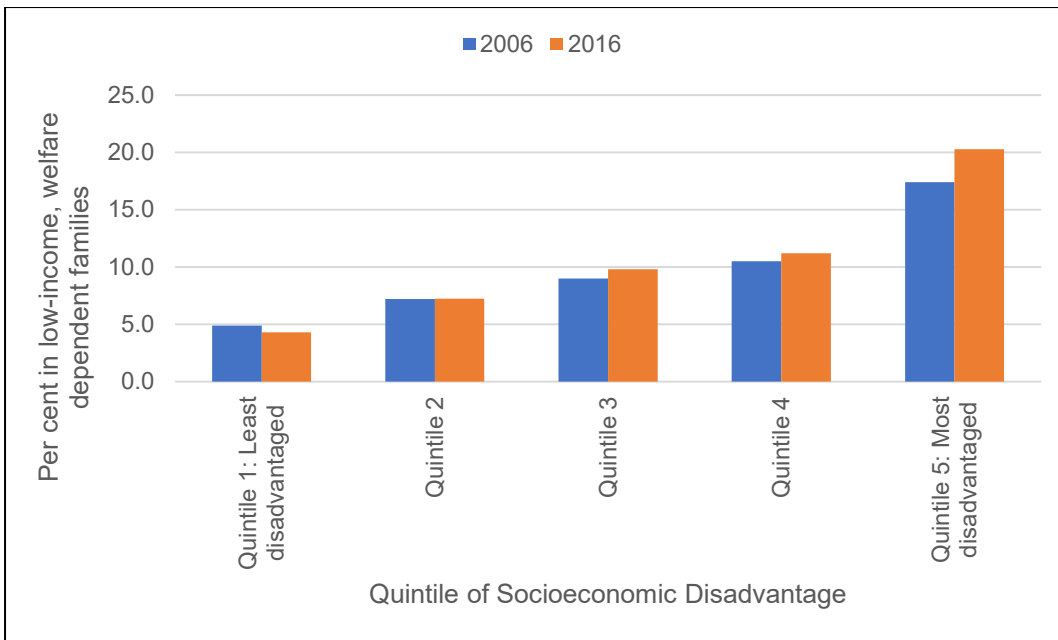


Figure 4.3: Percentage of people in low-income, welfare-dependent families (with children) in South Australia by quintile of socioeconomic disadvantage of geographic area in which cohort lives, 2006 and 2016 (Social Health Atlas, PHIDU, 2018)

The community and health sector experts, as well as economists, who we interviewed, and those who participated in the workshop all strongly advocated for a rise in Newstart, Youth Allowance and other payments, recognising that a great proportion making up the lowest quintile in the figures are from those receiving the majority of their income from these sources. The Australian Council of Social Service (ACOSS) argues that the freezing of Newstart Allowance (after inflation) since 1994 is contributing to a progressive deepening of poverty for people in households relying mainly on that payment.⁶¹ Furthermore, they argue that the social security policy changes since the Global Financial Crisis have increased child poverty instead of reducing it, especially in sole parent families. In 2009, the Parenting Payment was excluded from the pension increase, and Family Tax Benefits (FTB) were frozen, and in 2013, 80,000 sole parents were transferred from Parenting Payment to the lower Newstart Allowance.⁶¹ The rate of poverty among unemployed sole parents rose after many in this group were transferred to Newstart Allowance.^{36, 51}

Figure 4.4 on the following page reveals a pronounced social gradient in the distribution of people receiving unemployment benefits long-term in South Australia. Unemployment rose between 2006 and 2016, which has resulted in an increase in the long-term rate of receipt of unemployment benefits over this period in every quintile. The inequality ratio is very high, 3.82 in 2006 and 4.33 in 2016, indicating that those living in the most disadvantaged socioeconomic areas are four times as likely to be in long-term receipt of unemployment benefits compared with those living in the least disadvantaged socioeconomic areas. When examined together, the above data points to changes to the social security policy not being effective in reducing long-term unemployment or in increasing employment.

The interviewees discussed unemployment and social security within a broader narrative of a shift from social security being a social responsibility and citizens' right before the 1980s, to being increasingly framed in public policy and public discourse as a conditional safety net for a narrowing number of "deserving" people. This has implications for the health of the people receiving benefits,

both because they lack funds for necessities and because of the demeaning nature of the welfare system. A number of interviewees shared their concerns:

So, I think if we looked at just the whole nature of the discourse over unemployment benefits, we would see a demonisation of people that are receiving benefits of any sort. And, you know, that's evident in public policy where we have had the unemployment rate not increasing in real terms for 24, 25 years to the stage where even the business lobbyists are starting to say raise the rate. (NGO sector expert)

Even if you've got income through the welfare system, it is designed to be pretty mean deliberately. So it's not an attractive alternative to working... and that's by design. And, you know, what does it do to your self-esteem? And if you've got low self-esteem and you're being told constantly that you're not able to earn a living, there's something wrong with you, you know, that's not good for your health. (Economist and labour market expert)

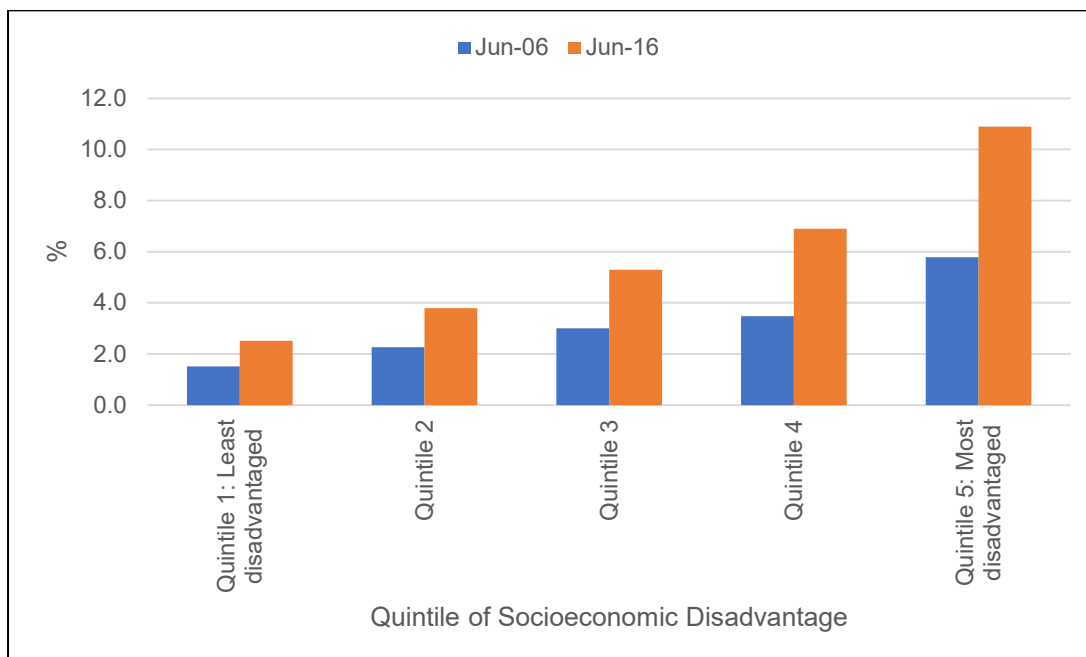


Figure 4.4: People receiving an unemployment benefit long-term by quintile of socioeconomic disadvantage of geographic area in which the cohort lives, 2006 and 2016, South Australia (per cent) (Social Health Atlas, PHIDU, 2018)

People living in South Australia continue to face the highest risk of poverty according to estimates for 2015-16.⁵¹ The rate of household poverty rose dramatically in South Australia between 1981-82 and 1997-98, from 10 per cent to 23.3 per cent.⁵⁰ People living in regional South Australia were two times more likely to be living below the poverty line than those living in Greater Adelaide Metropolitan areas in 2016 (7.1% of households in Greater Adelaide were below the poverty line; in the rest of the state, 14.8% were below the poverty line).⁵⁸ Those in receipt of government income support continue to make up a large proportion of the cohort experiencing poverty in 2015-16, with 81 per cent of households in poverty having at least one family member receiving a social security payment or pension.³⁰ Almost two-thirds of households in poverty (64%) have pensions and benefits as their main source of income.

The worsening economic situation for those in receipt of sole parent and unemployment payment is therefore even more concerning as it amplifies inequalities and adversity faced by groups who already experience heightened disadvantage.

5. Privatisation of public services exacerbates inequities

One of the key effects of the dominance of neo-liberal policies and ideas in Australia and globally has been the privatisation of previously public services and utilities, often into quasi-market structures. The link between privatisation and growing health inequity in South Australia was a major emerging theme in our interviews with experts. Privatisations have occurred in many different sectors, including health and social services, housing, education, and employment services. While privatisation has clearly been a national and global trend, Victoria and South Australia have undertaken the most comprehensive agendas of privatisation.⁵⁹ In South Australia, we note much of the privatisation which has occurred has been partial and regulation of the market forces common. These privatisations are often undertaken as a temporary relief of state funding, without a willingness to increase state tax revenue.

Box 5.1 The State Bank collapse clearly was a major thing that drove privatisation and contracting out in that '90s period (Public policy academic)

One event that was critical to the roll out of privatisation in South Australia was the collapse of the State Bank in 1991, which caused \$3 billion of public debt. To deal with the debt, in 1994 the Audit Commission advocated for public sector spending cuts and outsourcing of government activities and privatisation.⁶⁴ An Asset Management Task Force was set up by the Liberal state government to sell off government assets on the private market. Electricity was privatised, and water and sewerage services were outsourced to United Water.⁶³ The collapse also undermined the state Labor government's economic credentials, such that future Labor state governments sought to redress this negative image through austerity measures and surplus-focused budgets, particularly up to 2004 when the state was awarded a AAA credit rating.⁶⁵ In addition, the economic downturn following the State Bank collapse led to an increased outward migration from South Australia that disproportionately included people on middle and high incomes, and younger people (aged 15-29).⁶⁶

While South Australia has also had some of the most extensive privatisation of energy (electricity and gas) in Australia,⁶⁷ data does not suggest that there is a link between this privatisation and the increased energy prices discussed in 4.4.⁶⁷

Interviewees' reflections on the health and equity impacts of privatisation are discussed below by sector.

5.1 Housing

I think housing is probably the big one, one of the big ones. The fact that from the early 1980s we had an active attack on public housing from the private sector and so we've had policy move away from public housing provision to private provision and maximising returns to investors. (NGO sector expert)

South Australia has historically spent more on public housing than other states and territories.⁴⁴ The percentage of dwellings in the state rented from the state government housing authority has decreased drastically between 1986 and 2016, which most affected the most disadvantaged areas of South Australia (Figure 5.1).

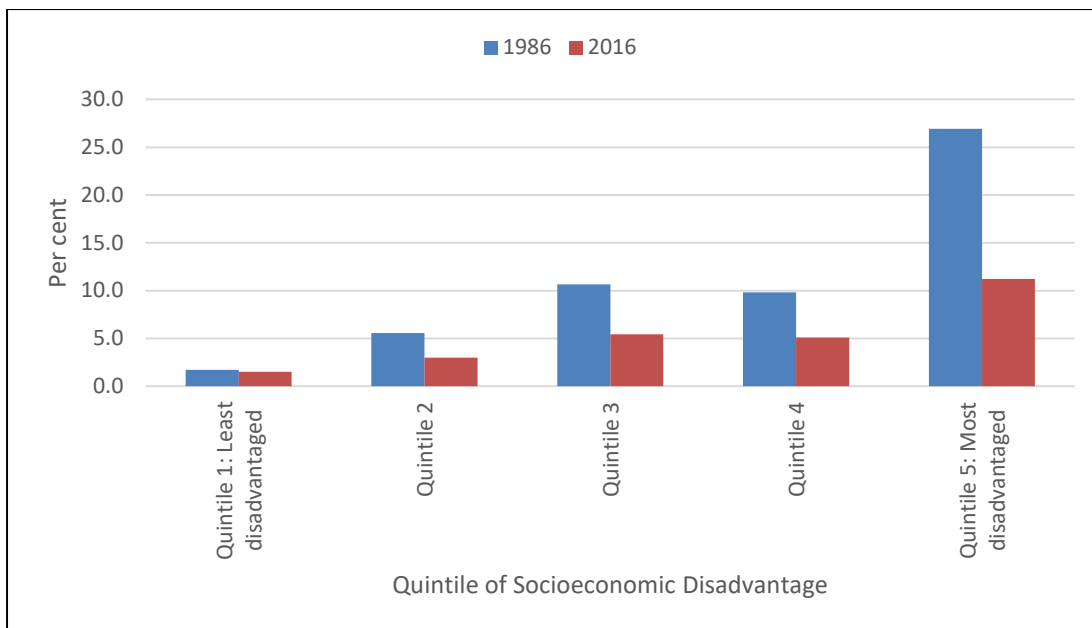


Figure 5.1: Percentage of dwellings rented from the government housing authority by quintile of socioeconomic disadvantage of geographic area in which the cohort lives, 1986 and 2016, South Australia (Social health atlas, PHIDU, 2018)

While this has been partially offset by an increase in non-government social housing, the total social housing stock in South Australia has still decreased from 64,491 dwellings in 1992 to an estimated 48,289 in 2015.⁶⁸ This has led to “huge” waiting lists, and pushed more low income people into the private rental market and, at the same time, housing policy has shifted from the government directly supplying and building housing to subsidising both individual renters and private developers to supply rental housing to people on lower incomes.

Interviewees emphasised that while this was a national trend, South Australia was particularly hard hit because it had been such a strong public housing provider previously, so the decline was more dramatic:

The [SA Housing] Trust role in South Australia ... at its peak was higher than ten per cent, than any other state. So therefore, the decline probably has had a bigger impact here actually. (Public policy academic)

It was also noted that Commonwealth funding formulas for housing had disadvantaged South Australia, and that funding had been negligible, “which means that you have to sell off properties just to stay afloat” (Public policy expert). One interviewee noted that changes in policies in other sectors – notably the deinstitutionalisation of mental health services – led to increases in demand for public housing while actual housing stock was declining. In addition, while public housing has decreased, affordability of housing has also decreased, meaning there is “a whole group of people” on “low and moderate incomes” who are falling through the gaps between having access to public housing, which “is only available for the very poor”, and being able to afford housing (Public policy expert).

South Australia did create 5,485 affordable houses between 2005 and 2015 through inclusionary planning which requires new developments to provide a certain percentage of affordable houses.⁶⁹ This creation of affordable housing represented 17 per cent of new housing supply in the state, but inclusionary planning relies on private development, and does not fulfil the unmet need for social housing.⁶⁹ The current unmet need for social housing is estimated at 25,500 social housing dwellings for Greater Adelaide and 7,600 in the rest of South Australia.⁷⁰ In addition to this, current

unmet need for affordable housing is estimated at 8,400 homes in Greater Adelaide and 1,900 in the rest of South Australia to assist households assessed as being in housing stress.⁷⁰

5.2 Health and Social Services

I think it's a bit like pissing against the wind. The country ended up being in the grip of – when you look at the last few decades – of neo-liberal policies and programs that made it impossible for health services to even cope. (Health policy expert)

The growth of the private health and social service sector was highlighted as increasing health inequalities in the state. One interviewee noted the role of private health insurance, and how it was driven by Federal policy decisions. Over the time period of interest, private health insurance coverage in Australia fell from just over half the population when Medicare was introduced in 1984 to less than a third by 1998. The Medicare Levy Surcharge, lifetime health cover, and rebates were introduced in subsequent years, and saw the rate of coverage increase to approximately 45 per cent for the next decade and a half.⁷¹ In primary health care, the extensive funding cuts to state government community health services in South Australia means that private primary health care services such as general practice are the main option available to people. One interviewee raised equity concerns around the incentives in fee-for-service private general practice:

And you'll find those mega-clinics; the greatest concentration is in fact in our lower socioeconomic areas, with the poorest health outcomes. So you'll be better off, rather than funding GPs per 10-minute consultation, having some element of "we're not going to fund you for every time you see that patient, we're going to fund you on how effective you are as a GP on managing that patient's condition." Essentially, keeping them out of hospital. (Health policy expert)

The loss of public sector community health services also meant there was little health promotion occurring in the state:

[In NSW] in their area health services they still have a strong presence of people whose job it is to promote health and prevent illness. I think they mentioned they have 330 health promotion workers or something. Well I don't know how many we would have in South Australia, but it would be a handful, you know, people who could say that in the public sector, in local health networks whose job it was to do that. (Health policy expert)

However, these cuts were towards the end of the period of interest (in 2013). The largely private and very inequitable dental system in South Australia was also noted to contribute to health inequities. One interviewee noted that privatisation "tends to change the way in which we get access to services. That's an important issue. So that's a link between why privatisation might have a negative effect on health inequalities." (Economy and labour market expert)

5.3 Education

I would abolish private schools. I think they are regrettable, very regrettable. They segregate society on religious grounds, on ethnic grounds and in terms of socioeconomic status. And when they offer scholarships to poor children, they just take the best and brightest children out of the public system. (Economy and labour market expert)

There has been a significant rise in private schools over the time period under consideration. Commonwealth funding per capita for private schools has increased steadily from 1970 to the 2000s.⁷² The proportion of students enrolled at private schools in Australia increased from just over 20 per cent in 1980 to over 30 per cent in 2000.⁷² Private schools disproportionately teach students from the top two socioeconomic quartiles.⁷³ There are large inequities in teacher shortages, educational resources, and educational attainment between schools in low socioeconomic areas

and schools in high socioeconomic areas, and these educational inequities are more pronounced in Australia than countries like Canada, New Zealand, the UK, and the Netherlands.⁷⁴ As the continuing Gonks reform failures highlight, addressing these inequities has been a challenge for governments.

During this period, there has also been a measured decline in educational outcomes. There has been a decline in the proportion of 15-year-old South Australian students achieving the national proficient standard in reading literacy between 2003 and 2012. This is a nationwide trend, with the South Australia score not significantly differing from the Australian average. There has been a similar decline in the proportion of 15-year-old South Australian students achieving the national proficient standard in mathematical literacy between 2003 and 2012, and on this measure, South Australian scores were significantly lower than the national average in 2012.

5.4 Job services

Several interviewees raised the privatisation of the Commonwealth Employment Service as a negative influence on health equity. The Federal Howard Coalition government created the privatised Job Network in 1998, however, the previous Labor Keating government had already privatised two thirds of the CES.⁷⁵ This period was also characterised by the rise of a punitive and obligation-focused model of unemployment support.⁷⁵ Since then, there have been several revisions of the privatised employment service system; renamed Job Services Australia in 2009, and Jobactive in 2015. The Senate Inquiry into Jobactive released its report in February 2019 (titled *Jobactive: failing those it is intended to serve*)⁷⁶ and this, along with the considerable negative media coverage,^{77, 78} highlights the perverse incentives through to fraudulent behaviour on the part of the private employment services.

One interviewee felt the for-profit job services were:

“providing no service at all and taking the money, getting paid by the placement, so their incentive is to provide multiple ridiculous unsatisfactory placements rather than place people into long-term jobs... It has been dreadful.” (Public policy expert)

Taken together, the findings for these sectors paint a picture of privatisation affecting a range of social determinants of health that drive a system less able to respond to health inequities, and is instead more likely to exacerbate these inequities in South Australia.

6. Managerialism and the hollowing out of the public sector – its contribution to South Australia’s growing inequities

This section of the report focuses on changes to the public sector as a result of the adoption of New Public Management and managerialism by both state and national public sectors. It describes how changes to the public sector have reduced South Australia’s capacity to respond to the economic and social challenges it has experienced since the 1980s and hence to the growing inequities in this state.

There is an extensive literature about the development and implementation of managerialism as part of a New Public Management approach in Australia. The New Public Management philosophy evolved in the public sector across Australia from the 1980s and focused on commercialisation, decentralisation of public services, corporatisation, contractualisation, outsourcing and

privatisation, and the creation of a contracted senior executive service with priorities shaped by a neo-liberal agenda.⁷⁹⁻⁸²

6.1 Politicisation of the public service

New Public Management has resulted in an increasingly politicised public service in Australia, evident in the now common replacement of senior public servants following a change of government to facilitate the imposition of the new government's control of and authority over the public sector.^{82, 83} This has been a significant move away from the Westminster model of an apolitical professional public service that provides impartial advice to the government of the day.

Five interviewees explicitly identified managerialism as leading to a loss of independent, frank and fearless policy advice to government and a hollowing-out of the public sector resulting in a loss of public sector policy capacity and expertise. Interviewees said:

If you get more than a normal number of people who are recruited to chief executive positions who are de facto chiefs of staff of Ministers, who are yes-sir, how far can I jump. Rather than fierce and frank conversations, you're going to get group think. If you're talking to the same types of people all the time that have your same views, you're going to come out with the same answer. I think there's been a progressive focus [in the public sector] on providing the right answers to their masters, the right political answers but not necessarily the right answers. (Health sector expert)

They are people who are simply enablers and they are there to execute the decisions and views of the government of the day and if their staff make their ministers uncomfortable, then they deal with the staff and it becomes very difficult for the staff. (Health policy expert)

In a South Australian context we've seen an expertise drain and a beating up of our public sector. I think at a national level we've seen centrifification of power so that decision making around stuff at a jurisdictional level is based more and more out of Canberra. (Social services expert)

Our interviewees suggested that this politicisation can be linked to a decline in the capacity of the national and state public sector to develop and implement sound evidence-based policy, described by a health sector expert as:

The gradual politicisation of the public sector and the creation of the external experts to do work that would be considered to be core. I think at the national and the state level the ability to actually think about and plan for and execute major initiatives across a population I think is really doubtful. We saw it during Rudd when they had the GFC and the Commonwealth tried to initiate some stuff, pretty badly. They don't have the engine room anymore to do it. And the state certainly doesn't. (Health sector expert)

This interviewee explained: "It gets back to that quality of bureaucrat, not being really on top of policy, not engaging, being too inward looking." The interviewee also suggested however, that there is recent evidence of a shift back towards merit-based appointments within the public sector, with the Liberal government elected in 2018 seeking quality policy advice over political advice:

So it's not about our ideology anymore. I'm not wishing to be political, but you've currently got a government that says, show me the evidence. I'm feeling a bit refreshed, actually. It's just the enormity of the task. (Health sector expert)

This comment may suggest a shift away from or a softening of managerialist approaches in the public sector in South Australia. However, it is too early to know if this will be the case.

The contractualisation and politicisation of the senior executive of the public service has resulted in a loss of leadership in the provision of independent policy advice.⁸⁴ An interviewee indicated that in South Australia over the last two decades this loss of leadership and the ongoing cuts to staffing

through departmental restructuring have resulted in a loss of policy development and implementation capacity.

At the same time, there has been a change in the way policy development is undertaken in the South Australian public sector. Interviewees concurred that policy development processes shifted from detailed, highly consultative processes where the support and agreement of stakeholders to policy positions and their implementation was established during the policy development process. Policy development became an internal process, and policy statements became very general, not necessarily including specific commitments. A health policy expert explained:

Policy has shifted from being this broad, detailed, deep process, because it was a process, not just a document, to being advice on specific issues. Originally it was advice on issues that sometimes we were aware of, so sometimes it involved waving flags of, you know, picking up on concerns and identifying things. Then in the end we were told “no we don’t want that, we will tell you when we want your advice on things”. [That reflects] both the reduction in public servant jobs, but also wanting to control, because of budget issues I guess, not wanting to make any commitments to anything that they may be held accountable for. (Health policy expert)

Another health policy expert explained that, regardless of the political party in power in Australia, there has been a growing resistance to policy actors advocating value-based policy positions, and that policy actors who are driven by a set of values and constantly advocate for their policy positions or investment priorities are “regarded actually as unwanted and dangerous.” (Health policy expert).

A health policy expert explained:

So, it’s a very different policy environment to the environment that prevailed in the ’80s when people who knew something about the industry sector that they were working in, whether they were at state or Commonwealth level, but were actually in positions. I mean, those people have all gone. It’s not unusual to find people working in policy and program areas who know absolutely nothing about the issues that they’re dealing with, apart from how to manage contracts. And they’re not encouraged to learn anything about the policy area either. (Health policy expert)

Box 6.1 – Lost opportunities – South Australian reform agendas not progressed

- *Our best investment: A state plan to protect and advance the interests of children – The Child Protection Review, (the Layton Review) March 2003*

A plan proposing a new paradigm for child protection and for preventing child abuse and neglect, including strategies to improve the provision of child protection services in South Australia and ensure better outcomes for children, young people and their families.

- *Better Choices Better Health: Final report of the South Australian Generational Health Review, (the Menadue Review) April 2003*

A framework to guide the transformation of the South Australian health care system over the next 20 years to ensure its future sustainability, with recommendations for systemic reform with an enhanced focus on primary health care and prevention.

- *State Housing Plan, March 2005*

A 10-year comprehensive state housing plan to address emerging pressures in the housing market, in particular declining housing affordability, focusing on new relationships between government, industry and the not-for-profit sector as the foundation for providing affordable and high need housing.

6.2 Undermining the role of policy

The undervaluing of public sector policy roles and the narrowing of policy processes to responding to specific requests for advice from senior public servants and the minister has meant that policy

actors necessarily have become reactive. There has been a shift in understanding of the public sector policy role from providing frank and impartial advice to the government of the day, to efficiently implementing the will of that government.⁸⁵ Combined with the significant staffing cuts to the South Australian public sector that have continued to be imposed from the 1980s, and most rigorously in the last decade, the limiting of the policy process has meant that policy actors are less able to have the capacity to build the expert knowledge base that is required to respond to new and emerging policy issues.

An interviewee suggested the significant difference in this experience in South Australia from that of Victoria and New South Wales has contributed to fewer inequalities in Victoria and New South Wales than in South Australia:

New South Wales were heading down a pretty bad way as well, but then they had, from a health point of view, they had the Garling Review and they reset themselves. Oddly enough, a Liberal Government reset from the Labor Government which was toxic at the time as you might recall. And they followed largely a modified Victorian model. And again, big policies on transport, really robust multi-agency responses on justice and child protection. (Health sector expert)

South Australia also conducted three major reviews in health, housing and child protection during 2003-2005 (see Box 6.1). The reports from these reviews recommended significant reform agendas and warned of the inequitable outcomes arising from continuing down the current policy path. However, the recommendations from the reviews were not implemented. A health sector expert described these review reports as “lost opportunities” for the state (see Box 6.1):

But the government of the day were being driven ruthlessly by what I'd call a managerialist Treasury. Treasuries are always managerialist. But they couldn't think ahead of the curve. And what these reviews were saying, “here's where we are now and it's pretty bad, but not that bad. Here's where this is going to end up.” They predicted what I think unfortunately has proven to be correct. (Health sector expert)

6.3 Intersectoral collaboration essential but not enough

South Australia has undergone a number of reforms intended to break down departmental silos within government and to encourage intersectoral collaboration. These included major reform strategies such as the establishment of the Department of Human Services (1997-2004), which incorporated health, housing, welfare and community services. South Australia's Strategic Plan (first launched in 2004, final version in 2011) was intended to drive intersectoral collaboration to break down “silos” and improve work across government agencies and with other stakeholder organisations to address the most intransigent and complex policy problems. There were also administrative reforms such as the introduction of Cabinet impact statements as a required Cabinet submission process to drive intersectoral collaboration.

The call for intersectoral collaboration to address the social determinants of health and improve population outcomes continues to be common, particularly among health promotion advocates. While it is suggested that the public sector operates in silos, one interviewee noted:

I think for a long time people in public health thought that if we could only get intersectoral actions happening to improve health outcomes, it would all be good. But the fact of the matter is intersectoral action happens very, very well in Australia, but it just so happens that it's in the interests of a conservative economic agenda and not in the interests of health. I mean, ministers and cabinets and senior bureaucrats know very well how to get coordinated intersectoral action, it's just that health's not the priority, full stop. (Health policy expert)

Intersectoral collaboration was a significant agenda for the Rann and Weatherill Labor governments (2002-2018). In particular it was evident in Rann's *South Australia's Strategic Plan*, which was

intended to drive public sector collaboration to address priority complex policy issues, such as homelessness, unemployment, and Aboriginal life expectancy. The Rann Labor Government also introduced the Adelaide Thinkers in Residence Program to South Australia (2003–2013). This program brought international experts to South Australia to bring vision and new ideas on intransigent policy problems.⁸⁶ In 2017, the Dunstan Foundation recommenced the Thinkers in Residence Program in a more limited form, with a specific focus on social innovation and social enterprise. The Weatherill Labor Government's 90 Day Projects approach was another initiative to drive government departments to work collaboratively and intensively over a limited time to identify solutions to complex multi-sectoral issues.

Other research conducted at the Southgate Institute for Health, Society and Equity has highlighted the shift in focus in South Australia away from addressing health equity through intersectoral collaborative approaches, to promoting intersectoral collaboration as a means of improving health alongside the core activity in other government sectors but without special attention to equity.⁸⁷

6.4 The loss of supportive pillars

If you've got a robust economy, you can waste a lot of money and still do some good. We haven't had a robust economy, which means everything we could do had to be targeted and done well. And I think, unfortunately, there are a lot of things, in fact, a lot of those supportive pillars have been taken out in the interests of short-term fiscal balancing without consideration of what the long-term fiscal outcome would be. (Health sector expert)

New Public Management approaches adopted by public sectors across Australia have hollowed out the public sector and supported the rolling out of the neo-liberal agenda. In South Australia, these approaches have resulted in a loss of vision in the public sector and have undermined its policy development and implementation expertise and its capacity to respond to South Australia's worsening social and economic circumstances and growing inequities.

7. Rise of the market and decline of collectivism: Erosion of social justice and community centred values and approaches

I think the big story really here is, an intellectual story about the rise of neo-liberalism and the collapse of social democracy. (Public policy academic)

Reflecting on their long-term experience in public, academic, community and NGO sectors, our interviewees and workshop participants painted a narrative of the erosion of democratic social justice values and community approaches to health and wellbeing and the expansion of neo-liberal individualism ideas both locally and globally. This trend towards individualism has been noted globally.⁸⁸ Both interviewees and workshop participants noted a number of ways this ideological shift has manifested in public policy and approaches to health and wellbeing.

7. 1 Individual responsibility over collective responsibility

With the rise of individual responsibility as a policy strategy in many sectors, there has been a move away from collective responsibility as a strategy for improving health and wellbeing, as demonstrated by a disinvestment by the South Australian government in health promotion and community development. Furthermore, the privatisation of job services reflects not only neo-liberal

austerity measures, but also a shifting of responsibility to care for people who need support away from the collective public realm.

I think that's a really important one as well because essentially it was the first time that we really turned the key on what used to be the CES and the Commonwealth's responsibility. It was the Commonwealth's job to make sure that people were well supported and we outsourced it. (Social services expert)

One interviewee highlights how neo-liberal individualism doesn't equate to an increase in individual control, but rather what is evident "is more centralised control. So, there's this individual responsibility but centralised control. We're forever, aren't we, having to send information into some central bureau" (Education sector academic). This is highlighted by the increasing conditions placed on job seekers and penalties if they do not meet those criteria.

7.2 Choice and consumer society: everything is framed within the market framework

Interviewees were concerned that essential public services have been increasingly framed through a consumerist lens in which value is only seen in economic terms. Through the example of increasing tertiary education costs, one interviewee highlights how consumerism has become the norm in the education sector:

It's treating everyone more like a consumer. The teacher is a service provider. They're not an educator, they're a service provider. And if I was to look at the progress of education and policy, I would say we could well find more pre-packaged program curriculum materials produced by some organisation that is just implemented by the service provider, a.k.a. teacher. (Education sector academic)

A consumerist framework can also be seen to be underpinning the development of the National Disability Insurance Scheme (NDIS). As an interviewee noted, "there's a lot of individualism built into there" and "choice" is commonly used as a vehicle for individualism and responsibility placed on the individual to navigate the service. Whereas, the founding idea for the NDIS "was actually about making things personal. That really what people are looking for is highly personalised services so that they actually do attend to who they are and they are knowledgeable about who they are" (Social services expert). Participants in the interactive workshop reinforced these concerns and predicted increasing issues with access and the quality of service delivery in the future.

Making the connection between consumerism, individual responsibility and the breakdown of the collective, it was argued this shift is "a stealing of what is common. It's a stealing of what we have that makes us, us... the responsibilities we have for each other is lost in this grab to be a consumer." (Education sector expert)

7.3 Services are driven by funding rather than need, leading to an erosion of local knowledge and community representation

A number of the interviewees and workshop participants noted how the re-configuration of community, social services and NGO sectors to be increasingly funded by the government has taken away the ability of these organisations to set their own agendas and respond to local population needs. One interviewee explained:

What we see emerge in the '80s particularly is a huge number of new programs and new services that are to be delivered by non-government organisations, but that are essentially wholly, or, if not wholly, very substantially funded by government. (Social services expert)

This has encouraged some NGOs to tailor their programs and work to the criteria of their funders: “it really shifted the dynamic around so that it was organisations then doing the government’s bidding rather than the government doing the bidding of the community” (Social services expert). This has meant often compromising the advocacy role which has been central to many NGOs. In addition to the diminishing capacity of organisations to advocate for the community, under this regime the pressure to compete with each other for limited funding has broader implications for collective responsibility and collective and collaborative responses to the community. The impact, as one interviewee described, has been:

... profound, because it separated out the reality of disadvantage and it's made it all a little bit more distant and it's kept the people a bit more distant from ... and as we've embraced managerialism, we've lost our connection to the people and the real stories. We get so busy dealing with things like our quality accreditation system or our health and safety system or whatever it is, we miss the reality of day-to-day life and the consequences of that. Then our programs and the policies that we end up setting don't bear relationship to the people who are most vulnerable. (Social services expert)

This not only results in a detachment from the local, but has also eroded the knowledge and capacity of many organisations to respond to community needs:

People at a local level have less and less authority and therefore the intelligence that they have about what's going on locally is not being afforded the same level of respect, it may not even be being sought. And so, as a consequence, we get programs that are not designed to be for the local situation. (Social services expert)

7.4 Loss of community health and education movements

A notable loss in the health and public services landscape in South Australia is the disinvestment in community health and education movements and activities. Interviewees interpreted this as a wearing-away of democratic and social justice values, and a missed opportunity to address the social determinants of health.

Back in the '80s, late '70s-'80s, we had very substantial investments in the development of a network of local community health services. That too involved mixed professional groups, so they were multidisciplinary. And they were positioned in communities that were often experiencing hardship; parts of the community often had high levels of hardship. (Social services expert)

I think somewhere probably getting closer to 2000 while I think, so there was a period where the investment in those activities and those instruments or those mechanisms and social infrastructure was increasing, but at some point we hit a wall and that seemed to almost turn off the tap. So, in the health sector what we started to see is the withdrawal from those investments and back to tertiary services; the withdrawal from giving real priority to some of the social determinants of people's health. (Social services expert)

These comments highlight a growing concern for the disintegration of community cohesion and collective responsibility for disadvantaged persons. The erosion of social democratic values, including those of community control and participation, was highlighted to be one factor which has led to the increase in health inequities in South Australia.

The current climate is in stark contrast to South Australia's previous leadership in community health. In the 1980s and 1990s, community health centres operated throughout the state, engaging in curative and rehabilitative work, disease prevention and health promotion. They originally had community boards of management, but these were replaced with fewer regional boards in 2004, and then these were disbanded in 2006.⁸⁹⁻⁹² Community health centres underwent a narrowing of focus to a more selective, biomedical model, being rebranded as primary health care centres, and later, GP Plus services, with a focus on chronic disease management and hospital avoidance. Following the state government's *Review of Non-hospital Based Services* in 2013, the centres'

funding was reduced, and they were further reoriented to ‘intermediate care’, with almost all health promotion and prevention functions cut. Detailed research has documented the loss of opportunities to prevent disease and promote the health of individuals and communities as a result of these policy changes.^{90, 92} Prior to these changes, South Australia had one of the strongest community health sectors in Australia, and so the loss of these centres was particularly dramatic in this state.

8. Conclusion

This report shows the consequences of a perfect storm of challenging global, national and state factors on South Australia over the past 30-40 years. These factors have resulted in South Australia’s increasing health inequities, despite continued increases in life expectancy and stagnation of average income. Unless there are changes to the way that the state and national government responds to these pressures, we predict that health inequity will continue to worsen and that improvements to life expectancy may halt or even go backwards in South Australia, as has been witnessed in the US and parts of the UK.¹⁰

The issues discussed in this report are complex and demonstrate that many reflect international and national trends and policies. However, South Australia can show leadership to reverse some of the impact of these trends through policies that ensure the state is able to weather the impact of these international and national forces more effectively.

The Lancet University of Oslo’s Commission on Global Governance for Health: ‘The Political Origins of Health Inequity’⁹³ asserted that what is required to motivate change is an explicitly political and moral perspective on health and equity. The report states:

Justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. We watch in wonder as life expectancy and good health continue to increase in parts of the world and in alarm as they fail to improve in others. (p.30)

The report also quotes the Durham Health Summit: “Leaders need to be value-based but also evidence-informed”. In creating this report, we have seen how this interplay between the two themes of evidence-informed and value-based policies was strongly represented in the interviewees’ and workshop participants’ views on how to create healthy public policy. We align with the Lancet University of Oslo Commission report in arguing for a moral assertion concerning the importance of justice to improve health inequities.

In conclusion, we note that climate change is predicted to have particularly severe effects on Australia and South Australia. Commentators considering the health impacts of this climate change also note that its health effects are likely to be experienced more by people living in disadvantaged circumstances.^{94, 95} This makes it all the more urgent that the federal and state governments take immediate action to address the drivers of increasing economic and health inequity in Australia and institute measures to reduce this and ensure that all Australians have an equal chance at a long and disease-free life.

10. Explanatory notes

Index of Relative Socio-Economic Disadvantage

Rate ratios are calculated by using the Index of Relative Socio-Economic Disadvantage (IRSD), which is based on the ABS Socio-Economic Indexes for Areas (SEIFA). The IRSD is defined in terms of people's access to material and social resources, and their ability to participate in society (ABS. Census of population and housing: Socioeconomic indexes for areas (SEIFA), Australia, 2016. Catalogue no. 2033.0.55.001). SEIFA is one of the most commonly used indicators of socioeconomic status. One limitation of SEIFA is that the relationship between socioeconomic status of an area and socioeconomic status of a household (or individual) within that area is far from perfect. It is acknowledged that there can be high socioeconomic status households living within low socioeconomic status areas, and conversely low socioeconomic households living within high socioeconomic areas (Peter Saunders. Report for the NSW Child Death Review Team on measuring socioeconomic status. Social Policy Research Centre Report Series, 08/12. 2012). Use of SEIFA-based measures of disadvantage are justified by the influence of area characteristics on status, and the likelihood of availability of services and environmental and economic conditions within an area affecting socioeconomic status of individuals living within that area.

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SA: THE HEAPS UNFAIR STATE

Why have health inequities increased in South Australia and how can this trend be reversed?

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