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Social determinants of health

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Social determinants of health is an Australia's health topic

- Built environment and health | 07 Jul 2022
- Natural environment and health | 07 Jul 2022
- Determinants of health for Indigenous Australians | 07 Jul 2022

On this page

Evidence supports the close relationship between people's health and the living and working conditions which form their social environment (Baum 2018; Wilkinson and Marmot 2003). Factors such as socioeconomic position, conditions of employment, the distribution of wealth, empowerment and social support – known collectively as the social determinants of health – act together to strengthen or undermine the health of individuals and communities.

The World Health Organization (WHO) describes social determinants as 'the non-medical factors that in fluence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems' (Senate Standing Committees on Community A fairs 2013; WHO 2022).

Social determinants form part of the wider determinants of health which also include the environmental, structural, economic, cultural, biomedical, commercial and digital factors in our lives (Department of Health 2021).

According to the WHO, the social determinants of health have an important in□uence on health inequities – the unfair and avoidable di□erences in health status seen within and between countries. In countries at all levels of income – including Australia – health and illness follow a social gradient: the lower the socioeconomic position, the worse the health (WHO 2022). See Health across socioeconomic groups.

Future analysis of integrated (linked) data has the potential to provide further insights into the complex links between social determinants of health and outcomes, and greater evidence for causal pathways to good health.

This page provides selected data to monitor key social determinants of health in Australia.

What are the social determinants of health?

'Social determinants of health' has rapidly become a central concept in population and public health, leading to the emergence of new theoretical models and frameworks.

Although there is no single de□nition of the social determinants of health, there are common usages across government and non-government organisations.

The WHO lists the following as social determinants which can in□uence health equity in positive and negative ways:

- income and social protection
- education
- unemployment and job insecurity
- working life conditions
- food insecurity
- housing, basic amenities and the environment
- early childhood development
- social inclusion and non-discrimination
- structural con□ict
- access to a□ordable health services of decent quality (WHO 2022).

Socioeconomic position

In general, every step up the socioeconomic ladder is accompanied by a bene□t for health (see Health across socioeconomic groups). The relationship is two-way – poor health can be both a product of, and contribute to, lower socioeconomic position.

Socioeconomic position is often described through indicators such as educational attainment, income or level of occupation.

- In 2021, 68% of people aged 25–64 held a non-school quali□cation at Certi□cate III level or above, an increase of 20 percentage points since 2004 (ABS 2021a) (Figure 1).
- Around 10.5% of the population lived in low-income households (de□ned as less than half the median equivalised household income) in 2017–18. This rate has □uctuated between 9.3% and 13.6% since 2003–04 (ABS 2019a; AIHW 2018) (Figure 1).

- Among major occupation groups, Managers had the highest average weekly total cash earnings in 2021 ($2,596), and Sales workers the lowest ($761) (ABS 2022a). The average weekly total cash earnings for Managers was 3.4 times as high as for Sales workers in 2021, compared to 3.5 times as high in 2016 ($2,298 and $652), and 3.2 times as high in 2012 ($1,926 and $607).

This Tableau dashboard shows recent trends in 3 key social determinants of health – education, unemployment and income.

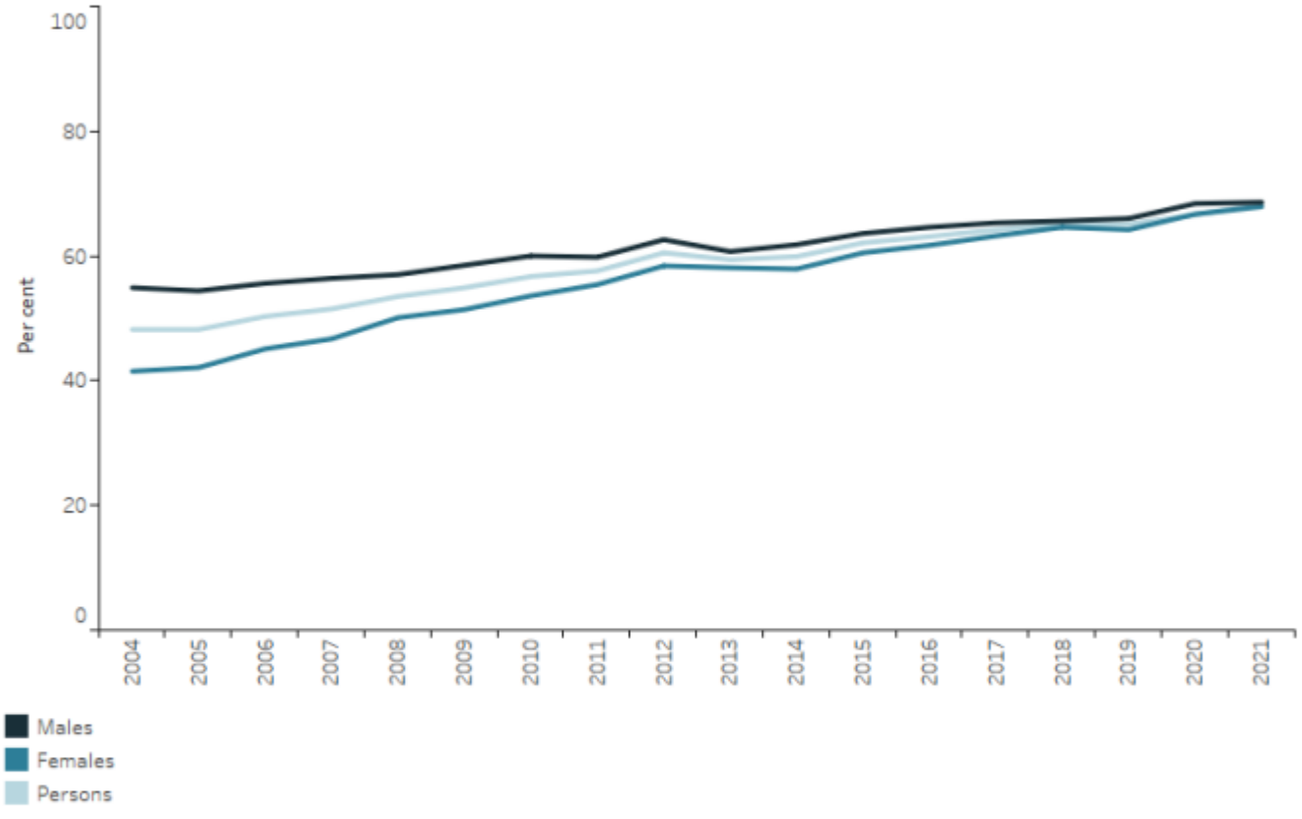
In 2021, 68% of people aged 25–64 held a non-school quali[illegible]cation at Certi[illegible]cate III level or above, an increase of 20 percentage points since 2004.

Data are also available for the Number of unemployed families with dependents, and for the Proportion of people living in households with an equivalised disposable household income less than 50% of the national median.

Figure 1: Selected social determinants of health, by disaggregation and period

Select disaggregation
Education

Proportion of persons aged 25–64 with a non-school qualification at Certificate III or above, 2004 to 2021



Note: From 2013, persons permanently unable to work were included in the scope of the Survey of Education and Work, and re-based estimated resident population data were used from 2014. These factors may affect the comparison of data over time.
Source: ABS 2021a.

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Early childhood

The foundations of adult health are laid in-utero and during the early childhood period. The di erent domains of early childhood development – physical, social/emotional and language/cognition – strongly in uence school success, economic participation, social citizenship and health (van Eyck et al. 2021).

- In 2020, around 334,800 children aged 4–5 were enrolled in a preschool program (ABS 2021d). Those children who lived in the highest socioeconomic areas were more likely to be enrolled in a preschool program (95% aged 4 and 22% aged 5) than those who lived in the lowest socioeconomic areas (76% aged 4 and 17% aged 5) (ABS 2021c). See Childcare and early childhood education.
- Between 2009 and 2018, the proportion of children entering primary school who were developmentally vulnerable on one or more Australian Early Development Census (AEDC) domains decreased slightly from 24% to 22%. In 2018, children living in the lowest socioeconomic areas were more vulnerable than children living in the highest socioeconomic areas (32% and 15% respectively) (AIHW 2020). See Transition to primary school.
- Some changes have taken place in the proportion of children considered to be developmentally vulnerable across the 5 AEDC domains. Between 2009 and 2018, the proportion of children developmentally vulnerable on emotional maturity decreased from 8.9% to 8.4%, language and cognitive skills decreased from 8.9% to 6.6%, and communication skills and general knowledge decreased from 9.2% to 8.2% (AIHW 2020).

Family relationships

An individual's family can in uence physical and mental health in a number of ways, including through creating a safe and supportive emotional and learning environment, and through providing access to services, products and activities.

As with other health determinants, the e ects follow a continuum from potential bene t in positively functioning and supportive families to potential disadvantage in families with abuse or neglect.

- 89% of all families with children aged 14–15 rated their family cohesion as good, very good or excellent in 2016–17 (91% for couple families, 81% for one-parent families) (AIHW 2021b).
- Children who have been abused or neglected often have poor social, behavioural and health outcomes in childhood and later life. In 2019–20, the rate of children and young people aged 0–17 who were the subject of a child protection substantiation was 8.7 per 1,000, an increase from 6.2 per 1,000 in 2009–10 (AIHW 2021b).
- In 2016, 1 in 6 women (17% or 1.6 million) and 1 in 16 men (6.1% or 548,000) had experienced physical or sexual violence by a current or previous partner since the age of 15 (AIHW 2019a). See Family, domestic and sexual violence.

Social inclusion

Social connectedness and the degree to which individuals form close bonds with others outside the family has been linked in some studies to lower morbidity and increased life expectancy. Strong social networks may bene t physical and mental health through practical and emotional help and support, and through networks that help people nd work or cope with economic and material hardship. See Social isolation and loneliness.

- Over the past 2 decades, around 1 in 5 people reported that they often felt very lonely (21% in 2001, 18% in 2010, 19% in 2019) (AIHW 2021a).
- In 2020, most people aged 18 and over (93%) reported being able to get support in times of crisis from people living outside their household, a similar prevalence to that in 2010 (94%) (AIHW 2021a).

Social exclusion is a term that describes social disadvantage and lack of resources, opportunity, participation and skills which are essential for full participation in society (See Glossary). Social exclusion through discrimination or stigmatisation can cause psychological damage and harm health through long-term stress and anxiety. Poor health can also lead to social exclusion.

- 1 in 4 Australians aged 15 and over (25%, or 5 million people) experienced some degree of social exclusion in 2018, with 6.0% (1.2 million) experiencing deep social exclusion, including 1.3% (260,000) who experienced very deep social exclusion (Brotherhood of St Laurence and MIAESR 2020). The prevalence of deep social exclusion has remained relatively steady since 2009, when it was 5.5%.
- 54% of Australians aged 15 and over who had a long-term health condition or disability experienced some level of social exclusion in 2018, with 16% experiencing deep social exclusion (Brotherhood of St Laurence and MIAESR 2020).

Employment and work

The psychosocial stress caused by unemployment has a strong impact on physical and mental health and wellbeing. Once employed, participating in quality work helps to protect health, instilling self-esteem and a positive sense of identity, while providing the opportunity for social interaction and personal development.

- The proportion of the Australian population aged 15–64 who are employed (employment-to-population ratio) has fluctuated over the last 15 years, from 72.4% in January 2007 to a low of 69.7% in May 2020 (reflecting the effects of COVID-19) to a current high of 77.0% in March 2022. Over the same period, the unemployment rate fluctuated between 4.0% in February 2008 to a high of 7.7% in July 2020 (reflecting the effects of COVID-19), with a current rate of 4.1% (March 2022) (ABS 2022b).
- In June 2021, there were 122,700 couple families with dependants where neither partner was employed (123,100 in June 2011), and 54,200 one-parent families where that parent was unemployed (48,200 in June 2011) (ABS 2021b) (Figure 1).
- In January 2022, 1 in 14 (7.0%) employed people aged 15–64 were underemployed (not working the hours they would like to, and available to work) – 5.8% and 8.3% of the male and female labour force, respectively (ABS 2022b).

See Employment and unemployment.

Housing and homelessness

Access to appropriate, affordable and secure housing can limit the physical and mental health risks presented by factors such as homelessness and overcrowding.

Evidence also supports a direct association between poor-quality housing and poor physical and mental health (Baker et al. 2016). Young people, Aboriginal and Torres Strait Islander people, people with long-term health conditions or disability, people living in low-income housing, or people who are unemployed or underemployed are at greater risk of living in poor-quality housing.

- More than 116,000 men, women and children, or 50 per 10,000 population, were estimated to be homeless on the night of the 2016 Census of Population and Housing, an increase of 10% from 45 per 10,000 population in 2006 (ABS 2018) (Figure 2.1). See Homelessness and homelessness services and Health of people experiencing homelessness.
- 43% of low-income households were in rental stress in 2017–18, spending more than 30% of their gross income on housing costs. In 2007–08, 35% of low-income households were in rental stress (ABS 2019b) (Figure 2.2). See Housing affordability.

- In 2018, overcrowding in social housing, based on those households needing one or more extra bedrooms, was 4.9%. Overcrowding was higher for Indigenous households at 14% (AIHW 2019b). See Indigenous housing.

This Tableau dashboard shows recent trends in 2 key social determinants of health – housing and homelessness.

The rate of homelessness has changed from 51 per 10,000 population in 2001, to 45 per 10,000 population in 2006, 48 per 10,000 in 2011 and 50 per 10,000 population in 2016.

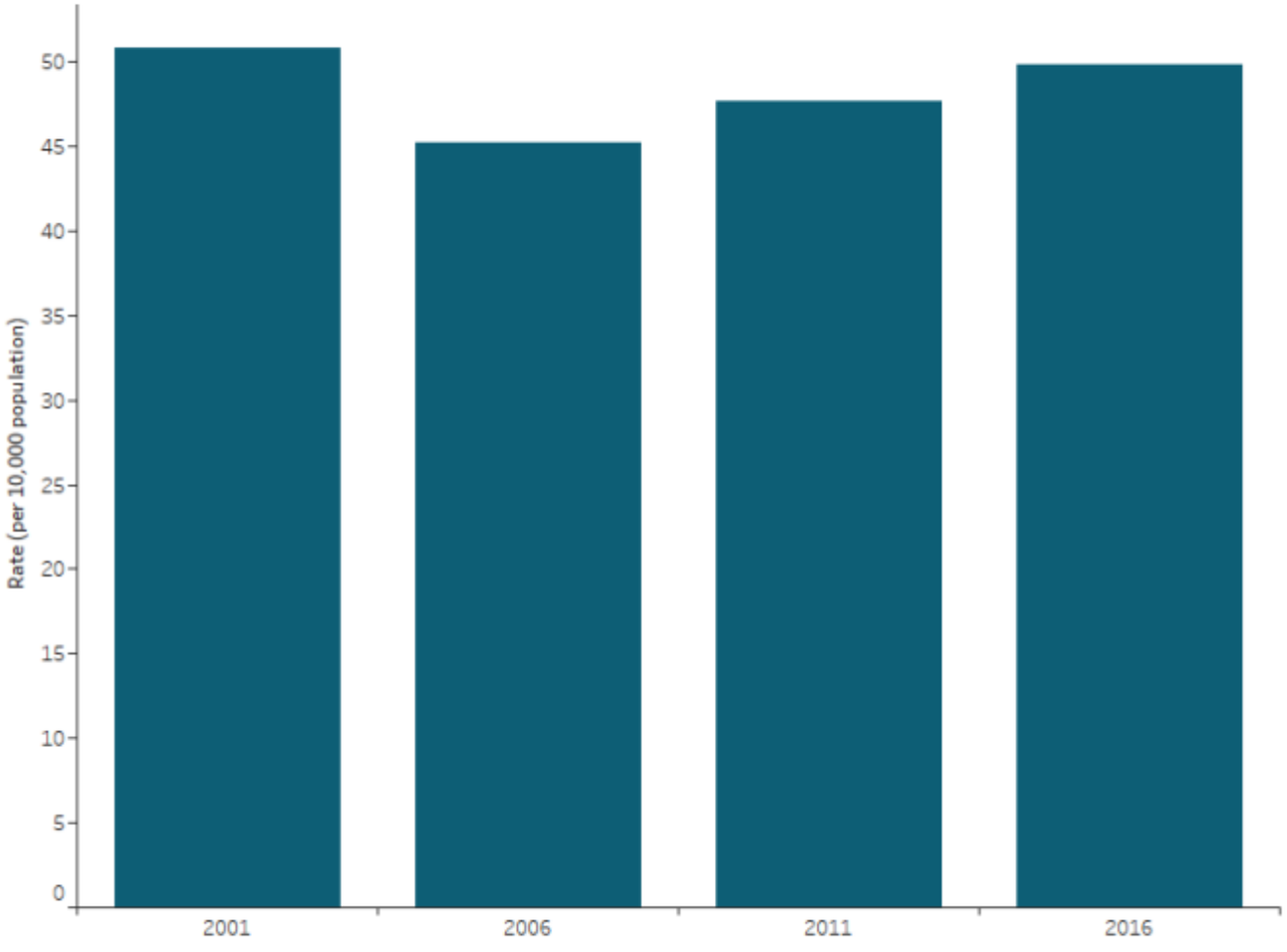
Data are also available for the Proportion of low income households in rental stress, 2007–08 to 2017–18.

Select disaggregation

(●) Figure 2.1 Homelessness

( ) Figure 2.2 Housing

Figure 2.1: Rate of homelessness, people per 10,000 population, 2001 to 2016



Source: ABS 2018

http://www.aihw.gov.au/

Impact of COVID-19 on social determinants of health

Evidence has shown that infection, hospitalisation and mortality among some population groups have been disproportionally a ected by the COVID-19 pandemic, making the impact one of inequality (WHO 2021). The impact extends to the social determinants of health, with adverse e ects on income,

education, employment, and housing more pronounced among lower socioeconomic groups. These eﬀects can then act to worsen health inequities.

Evidence has also shown there has been an increase in psychological distress during the COVID-19 pandemic, which may be associated with social inclusion and loneliness (AIHW 2022).

See 'Chapter 2 Changes in the health of Australians during the COVID-19 period' in Australia's health 2022: data insights.

Where do I go for more information?

For more information on social determinants of health, see:

- Australia's welfare snapshots
- World Health Organization Social determinants of health - external site opens in new window (https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1)

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