advocates and implementers of policies that will create a fair and just society where opportunities for health are equitably distributed.

References


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A global perspective on health promotion and the social determinants of health

David Sanders

The development of the health promotion strategy and growth of the associated health promotion movement since the late 1980s is based on five interrelated components: the integration of policy in all health-related sectors and issues; the creation of supportive environments; the strengthening of community action; the development of individuals’ skills in applying health knowledge and undertaking advocacy; and the reorientation of services towards the promotion of well-being.1

This strategy employs a combination of advocacy, community mobilisation, capacity building, organisational change, financing and legislation to secure its implementation. This policy action has been focused on such settings as cities (in the Healthy Cities initiative), and subsequently in schools, markets, workplaces, hospitals and districts.2 Many of these initiatives have garnered political support and encouraged local agencies and sectors to reassess and change their policies and practices in influencing health.

While such initiatives have often catalysed significant activity and effective health action, their impact, replication on a large scale, and sustainability face continuing challenges. Using Africa’s health crisis and its current trade dispensation as a focus, this editorial will argue that such challenges are likely to grow and to increasingly compromise both the process and impact of health promotion initiatives unless the dominant pattern of neo-liberal economic globalisation is reversed, or at least substantially moderated.

What, then, is the global health situation and what is the role of social determinants in influencing this? Many recent authoritative documents, including the Commission on Macroeconomics and Health (The Sachs Report),3 have emphasised the widening gap in health experience between rich and poor countries, the rapidly increasing and intolerable burden of ill-health affecting the poor, especially in sub-Saharan Africa (SSA) with its deepening poverty and devastating HIV/AIDS epidemic.4 Indeed, it is partly in response to this crisis that most of the world’s governments committed themselves at the United Nations General Assembly in 2000 to the Millennium Development Goals (MDGs). Three of the goals, which involve reducing child and maternal mortality and reversing the spread of HIV/AIDS, malaria, and other communicable diseases, are explicitly health related. Four others directly address crucial social determinants of (ill) health, such as extreme poverty, undernourishment, living in slums, the subordination of women, and lack of access to education, safe water and basic sanitation.5 They are therefore also directly relevant to health equity.
The best available data indicate that while substantial progress has been made towards achieving the MDG targets in some regions, in others the situation is grim. An assessment prepared for the first World Health Organization High-Level Forum on the Health Millennium Development Goals in January, 2004, concluded that: “Even if economic growth accelerates ... and even if progress toward the gender and water goals were to be substantively accelerated, the developing world will wake up on the morning of January 1, 2016 some way from the health targets – sub-Saharan Africa a long way”.6 In SSA, key health indicators are at much worse levels than those in any other of the world’s developing regions (with the exception of malnutrition in children under five in South Asia, but there – unlike SSA – the situation is improving).

At the heart of the poor state of health in Africa lies a failure to tackle extreme poverty, with 44% of the population living on less than $1 per day – a greater proportion than 15 years ago.8 While the number of people living in poverty (less than $2 per day) in SSA increased from 289 million to 514 million between 1981 and 2001, world GDP increased by $18,691 billion. Africa’s situation is due to several interrelated factors – mainly economic stagnation with the related debt crisis. IMF and World Bank support for countries with crippling debt has been contingent upon governments adopting painful structural adjustment programs, entailing strict ceilings on government spending in the social sectors, limits on public sector recruitment and trade liberalisation. More recently, Poverty Reduction Strategy Processes (PRSPs) have been introduced that may include “trade-related conditions that are more stringent, in terms of requiring more, or faster, or deeper liberalization, than WTO provisions to which the respective country has agreed”.9 Thus, many developing countries have decimated their domestic economic sectors, such as textiles and clothing in Zambia10 and poultry in Ghana,11 by lowering trade barriers and accepting the resulting social dislocations as the price of global integration. Similarly, in Mexico, the liberalisation of the corn sector under the North American Free Trade Agreement led to a flood of imports from the United States, where agribusiness is massively subsidised. Mexican corn production stagnated while prices declined. Small farmers became poorer and 700,000 agricultural jobs disappeared. Rural poverty rates rose to more than 70%, the minimum wage lost more than 75% of its purchasing power, and infant mortality rates among the poor increased.12

In addition, national institutions in many African countries are frequently weak, leaving governments open to corruption; and conflict has affected several African countries with devastating consequences for health. The HIV/AIDS emergency has undoubtedly contributed, with on average one in every 14 adults infected with HIV – a rate far in excess of that in any other part of the world. Although itself a major health problem, HIV/AIDS is also a potent determinant of greater impoverishment and thus of further ill-health.

Trade is increasingly important in influencing social determinants of health, not just in poor but also in rich countries. For example, the Global Strategy on Diet, Physical Activity and Health, which is key to reducing the alarming rise in obesity and related chronic diseases, failed to get beyond a limited ‘sanitary education focused strategy’ partly because of opposition from the food and beverages industry whose financial resources far exceed WHO’s budget and whose interests were strongly represented by US representatives at WHO.13 Liberalisation of trade in services relevant to health is accelerating, partly as a result of the implementation in many countries of aspects of the World Trade Organization-administered General Agreement on Trade in Services (GATS). There is, for example, compelling evidence from some South African cities of how the pressure for local government to become more ‘entrepreneurial’ is leading to privatisation and escalating costs of basic services such as water and sanitation, and increasing numbers of water cut-offs because of non-payment in poorer neighbourhoods.14 The consequences for health are likely to be adverse.

Trade is but one of the dimensions of globalisation that has a big impact on (especially poor) countries’ abilities to implement healthy public policies. Other important factors undermining equitable economic growth and investment in public sector service provision are unregulated financial flows (‘hot money’), corporate and individual tax evasion, and dwindling development assistance.

It is clear, then, that the formulation and implementation of national public policies that involve addressing the social determinants of health are increasingly circumscribed by factors that derive from global economic structures and geopolitical relationships. This is especially the case for poor countries whose health needs tend to be more profound and urgent. In her Leavell Lecture in 2003, Ilona Kickbusch, one of the architects of health promotion, in calling for a “Third Public Health Revolution”, urged a move from a charity model of public health to one that recognises rights of citizenship and to a focus on the political determinants of health and globalisation, insisting that: “We need to build a global system of responsibility that ensures access to basic health even when states fail”. Her model has at its centre the strengthening of global governance structures as the means to achieve this.15

The history of public health has shown social mobilisation to be the key factor that has rendered governments – both national and global – accountable and responsive. In this regard it is urgent for the public health community to continue to advance health promotion strategies but also proactively (re)assume its historic role of supporting social mobilisation through, at a minimum, producing evidence of the negative aspects of globalisation and its effects, and of the positive health impact of equitable policies. In this way we may contribute to the achievements of the laudable – but receding – goal of responsible and responsive local and global governance and thereby address the determinants of ill-health.
The social determinants of health: what are the three key roles for health promotion?

Dennis Raphael

Renewed interest in the social determinants of health represents yet another cycle of recognition of their importance that began in earnest in the 1850s with the writings of Frederick Engels and Rudolph Virchow. For more contemporary health promoters, the focus on early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, social safety net, social exclusion, and unemployment and employment security produces a déjà vu experience recalling the Ottawa Charter’s health prerequisites of peace, shelter, education, food, income, stable ecosystem, sustainable resources, social justice, and equity. There was excitement then about addressing these structural determinants of health. There is excitement now about addressing the structural determinants of health. Restraining this enthusiasm and its policy outcomes in 1986 was the reality that the world’s English-speaking nations were on the cusp of a neo-liberal resurgence in public policy that served to effectively squash attempts to restructure society in favour of health. Now, 20 years later in the midst of neo-liberal inspired economic globalisation, we are again being urged to identify and modify the structural determinants of health that have since decayed in the interim. How likely are we to succeed in these efforts? The renewed focus on social determinants of health as exemplified by numerous volumes on the topic and various international, national, and regional initiatives can be traced to efforts by researchers to identify the specific exposures by which members of different socio-economic groups come to experience varying degrees of health and illness. While it was well documented that individuals in various socio-economic groups experienced differing health outcomes, the specific factors and means by which these factors led to illness remained to be identified – at least by social epidemiologists unfamiliar with the sociology of health literature. It is no accident that the term ‘social determinants of health’ made its contemporary appearance in a United Kingdom volume concerned with policy, social organisation, and health. Certainly, focus on structural determinants of health is a vast improvement over the dominant health promotion paradigm and activities associated with the holy trinity of risk of tobacco use, diet, and physical activity. It also represents an approach more consistent with the empirical evidence concerning the determinants of individual and population health.

The importance of the political and economic context

But a focus on the social determinants of health raises another important question that is infrequently considered by health

References

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