Guest Editors

This theme issue of the Journal focuses on a critical but surprisingly neglected aspect of health promotion practice, the social determinants of health. As Guest Editors, Liz Harris and Fran Baum have done an absolutely outstanding job in attracting high quality papers and overseeing the reviewing and revision processes. They have delivered, on time, not only the largest ever issue of the Journal, but a substantial contribution to the international health promotion literature. Many, many thanks from the Joint Editors!

Chris Rissel, Adrian Bauman and Jan Ritchie

Equity and the social determinants of health

Fran Baum and Liz Harris

This special issue comes at a time when interest in the social determinants of health is increasing internationally. In the face of rapid economic globalisation and the emergence of significant infectious and chronic health problems of potentially pandemic proportions, the social and economic effects of public and private sector policies on health and its determinants are becoming too stark to ignore.

During the 20th Century life expectancy increased significantly. Between 1901 and 2001, life expectancy at birth rose by 23 years for men and 24 years for women in Australia. Yet while there have been absolute increases in life expectancy for most groups around the world, considerable inequalities remain between people from different social classes, ethnic backgrounds and gender. Many of these differences result from differential access to the conditions that promote health, such as employment, education and basic health hardware such as safe drinking water, waste disposal and sanitation systems, these differences can be considered unfair or inequitable. The promotion of health across populations and ensuring that this is done in a manner that reduces these inequities is crucial. We agree with Starfield’s editorial that much of the research and comment on the social determinants of health does not have an equity focus and that it should do so.

Recognition of the importance of the social determinants of health is not new. The public health reformers of the 19th Century clearly recognised their importance. Among the most progressive, the Silesian doctor Virchow, was clear that the health of workers in the 1840s was directly related to the working conditions they experienced. The sanitary reforms in 19th-Century Britain were based on an understanding that environmental conditions had a direct affect on health. The work of McKeown noted that the 20th-Century life expectancy improvements had more to do with changing living conditions than to do with medical therapies.

Szreter’s analysis added further to the understanding that local government civic reforms played a crucial role in the environmental improvement. These reforms did not just happen as a matter of course, but often resulted from significant social and class struggle. There is a new focus on social determinants in the early 21st Century which may reflect the fact that the current form of economic globalisation is tending to increase inequities within and between countries and the logic of focusing on social and economic change is compelling.

Public health has largely assumed that life expectancy would continue to rise. The experience of several regions of the world now negate that expectation and, from a global perspective, sustainable and equitable health advancement is not yet secure. In Africa, an HIV/AIDS pandemic has resulted in falls in life expectancies in many countries. In eastern Europe, following the fall of the Soviet Union and the rapid introduction of market reforms, life expectancies of men fell. Predictions are being made that in the rich countries younger generations may experience falling life expectancies compared with their baby boomer parents because of increased chronic diseases, partly attributable to the impact of the ways in which the social and built environment are affecting physical activity and nutrition.

The formation of the Commission on the Social Determinants of Health by the World Health Organization in 2005 is a clear sign of the recognition that there needs to be greater focus on these upstream determinants or, as the Commission has called them, the “causes of the causes”. The Commission has positioned itself as emerging from the tradition of Alma Ata and the Ottawa Charter, as Solar and Irwin make clear in their paper on the historical legacy inherited by the Commission. This legacy is also noted by Baum and Simpson in their paper, which cites as examples of early actions on social determinants the work of past Australian governments such as Menzies federally and Dunstan at the State level in South Australia. The Commission will report in 2008 and is challenging countries to base their public health policies on an understanding of the importance and centrality of the social determinants of health to improving health equitably.

A social determinants approach poses many challenges for health promoters. Perhaps most significantly, much health promotion starts with a focus on individuals and, in the past, has been strongly associated with attempts to change behaviour. The limitations of this approach have been noted, but the individualism associated with it still dominates much health promotion research and practice. While some attempts to change behaviour have met with success (such as smoking and reducing fat consumption), the focus on individuals has been supported by policy change and has had more success with better-off people. Thus, the net effect has been to increase inequities.

The social determinants require a focus on policies, organisations and social structure. Some papers in this issue provide evidence of a shift in focus. Migliorini and Siahpush consider how where you live may affect your likelihood of smoking. Viola looks at
the question of how schools integrate nutrition into core school curriculum in remote Indigenous communities. Willis et al considers the importance of the cost and supply of an essential service such as electricity, O'Dwyer and Coveney detail the existence of food deserts in Adelaide, and Nolan et al looks at the factors behind food insecurity. In each case, these pieces of research do not focus directly on individual health or health status but look upstream to how the structures people live in shape their health experience. This should be an increasing focus of health promotion research so that we develop a better evidence base about the “causes of the causes” of illness and about the factors that create health and well-being.

The ways in which the social determinants affect the health of individuals is obviously complex – the “causes of the causes” requires looking upstream to social and economic structures that shape our chances of health and illness. Unlike behaviours that are evident and obvious, these structures are largely invisible in everyday life. These structures need to be recognised and the history, values and assumptions on which they have been based clearly understood.

King demonstrates the need for this to change and for health promotion to be a sustained effort. Mouy and Barr point to the important work done by the Victorian Health Promotion Foundation in shaping programs around the structures that determine behaviours rather than the behaviours themselves. The commissioning of this issue on the social determinants by the Australian Health Promotion Association reflects its growing leadership in focusing on social determinants and equity as a means of promoting health. This is very welcome and further development of this work encouraged.

While most health is created outside the formal health sector (that can more accurately be described as an illness care sector), this sector does have a vital role as the place in government that has a particular responsibility for health. Boxall and Leeder call for significant reform to the operation of health systems that would include more co-ordination and focus on health promotion. Newman et al. review the action each Australian jurisdiction takes in regard to health inequity and demonstrates that Australia can still claim to be one of the world leaders in terms of social determinants action for equity, but that our performance is patchy. There is certainly much room for improvement.

A focus on the social determinants of health has to be seen in a global context because so many of the determinants themselves are affected by global trends. This is reflected in contributions in this issue. Sanders demonstrates the massive inequities in health that exist globally but especially in sub-Saharan Africa. He argues very convincingly that the global economy does not promote health for the majority of the world’s population and is the most fundamental determinant of health. He particularly sees global trading patterns as in need of reform. Brown and Ritchie point to the global nature of the environmental crisis we face, rightly noting that unless action for sustainability is taken humans face a bleak future on this planet.

Given that the distribution of the social determinants will always have to be argued for against powerful forces whose interests may be threatened, the need for advocacy is a common theme in many of the papers in this collection. Sanders discusses the need for social mobilisation to advocate against unfair trade. Baum and Simpson suggest that the Commission on the Social Determinants of Health provides a great opportunity for advocates to use the work of the Commission and its Knowledge Networks as a powerful advocacy instrument in arguing for policy change. They also note that the Commission is one of the first such bodies to involve civil society in a central way.

King argues that health promotion has a responsibility to undertake advocacy for social change. Irwin and Solar show that the history of social determinants has been one of social struggle before positive change is achieved. Narayan points to the growing People’s Health Movement as a vibrant network of social movements that take action on the social and economic determinants of health as fundamental to improving the health of the world’s poorest people. Gleeson and Alperstein point to the work of a New South Wales-based advocacy group that is bringing together professional associations to look at how they can collectively lobby for change. Furler writes about the potential role of general practitioners and their professional associations.

Our hope is that the coming years will see action on the social determinants of health as part of the core business of health systems. Across the world it is being recognised that this action will be based on across-government action. This raises important questions about who should take responsibility for ensuring this co-ordination happens and that progress towards improved and more equitable health is monitored.

Such leadership is difficult for our existing health systems. However, there are some signs that this may be changing as the social and economic benefits of preventing chronic health problems, developing systems to combat emerging infectious disease, and addressing health inequity are outweighing the costs of inaction. Across Australia we are beginning to see some evidence that these issues are being taken seriously. Investment in cross-sectoral programs in the early years of life, community strengthening and crime prevention programs, the promotion of physical activity and improvements in urban design are signs of this change.

The extent to which the health sector can lead or value add to the work of other sectors on these issues will require change in priorities and practice. The lessons from history would suggest that this change will take time, be contested, and require change in the ways in which we all think about what we are doing. In the short term, this may involve lobbying for a specific proportion of health budgets to be allocated to prevention and early intervention, bi-annual reporting of progress against an agreed set of cross-sector social indicators for health and well-being, and open debates on the values upon which we want our society to be built. In the longer term, health promoters need to be
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.

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. 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 neoliberal 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), 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. 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. They are therefore also directly relevant to health equity.