The Social Determinants of Health

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Executive Summary

Over many years the term ‘health’ has been defined in various ways. Nevertheless it is widely acknowledged that health is a multi-dimensional concept that transcends the mere absence of illness. Our experience of health and wellbeing is contributed to by employment/income, social status, education/literacy, housing and environment, early life experiences and genetics, access to nutritious food, individual behaviours and lifestyle factors and access to appropriate and effective primary health care.

To acknowledge and investigate the influence social and environmental factors have on the health of individuals and groups is not a recent concept. Advances in medical treatments and in the human lifespan over the last 150 years have been greatly influenced by improved living and working conditions in the Western world. It is important to note however that the gains enjoyed by many thereby have not been felt by all within society. Despite unprecedented economic gains both nationally and in South Australia, the gap between rich and poor is widening, and health care, education and other human services are struggling to cope with demand.

Governments in developed nations are increasingly embracing the concept of the social determinants of health and wellbeing, and are cognisant of the role they play in ameliorating the social impediments contributing to social inequity. Health promotions both in Australia and overseas are increasingly being targeted at those at greatest risk. However to recognise the impacts on South Australians’ health of all government policies, across all portfolios, a more holistic approach to health policy development is needed.

The health and health care of South Australians continues to be a growing and increasingly complex set of competing priorities from various perspectives: from the individual, across local, State and Federal governments, to health care professionals and the health care system. This complexity and competing interest is to be expected in a sector that costs Australia over 9% of its gross domestic product , or over $3,500 per person per year.

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Introduction

Health is a multi-dimensional concept that transcends the mere absence of illness. Much of primary health care's focus stems from the Declaration of Alma-Ata, released following the International Conference on Primary Health Care in Alma-Ata USSR, September 1978. The Declaration set out a focus that is still embraced in varying forms today, and underpins the social determinants of health. The principles contained within the Declaration encompass notions such as:

- Health inequity within a country is socially, politically and economically unacceptable and is therefore a concern both for government and wider society.
- Individual and community participation in the planning and implementation of their health care.
- Governments should adopt cross sectoral strategies as part of national primary health care plans to address the health of all citizens.
- Governments have a responsibility for the health of its citizens and this can only be achieved by the provision of adequate health and social measures.
- Primary health care systems should be developed that are based upon sound scientific and socially acceptable methods and technology. This system should be created in partnership with individuals and community members and be accessible to all, at a cost that the community and government can afford to support and maintain human development across the lifespan[1].
- The understanding that good health for all underpins and advances social and economic development[2].

The concept of primary health care that emerged from this conference and the subsequent Declaration has shaped many of the strategies seeking to improve the health care systems overseas around the world, including Australia. In fact, the pursuit of a more community-centric, responsive, effective and efficient health care system still motivates health care workers across the world [3].

[1] World Health Organisation, (1978) 'Declaration of Alma-Ata' International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978, Viewed 31 March 2008, www.who.int/hpr/NPH/docs/declaration_almaata.pdf
[2] Baum, F, (2007), 'Health for all now! Reviving the spirit of the Alma Ata in the twenty first century: An introduction to the Alma Ata Declaration', in *Social Medicine,* Vol. 2, No. 1, March 2007, pp. 34-41.
[3] *Ibid, 34.*

Definitions of 'health'

The World Health Organisation (WHO) defines 'health' as

> "*a state of complete physical, mental and social wellbeing and not merely the absence of disease, injury or infirmity"*[4].

The term 'health' involves subjective and objective elements, environmental and government policy components, as well as individual and cultural elements that all affect the health of our populations. A useful definition of health was devised by Rootman and Raeburn:

> *"Health has to do with bodily, mental and social quality of life of people as determined in particular by psychological, societal, cultural and policy dimensions"*[5].

So if our experience of 'health' is related to our state of 'wellbeing', what exactly is 'wellbeing' and how is it achieved? *The Oxford Dictionary* defines 'wellbeing' as:

> *"The state of being comfortable, healthy, or happy"*[6].

The Macquarie Dictionary is unsurprisingly similar by describing 'wellbeing' as:

> *"Good or satisfactory condition of existence"*[7].

But do these definitions go far enough to describe the importance of 'wellbeing' to our health and longevity? The term 'wellbeing' encompasses much more of the human experience and describes our ability to respond to or take control over everyday challenges and changes[8].

To acknowledge that social and environmental factors influence the health of individuals and groups is not a 21st century concept; it is recognised that significant gains in health and longevity over the last 150 years have been due to vast improvements in the living and working conditions in the Western world. However it is also acknowledged that the immense progress in the treatment of illness that should be enjoyed by all are constrained by widening inequalities in health, and the effects of public health care systems that are grossly under-resourced and unable to cope with demand[9].

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[4] World Health Organisation, 1948, 'Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[5] Frankish, C.J., Green, L., Ratner, P., Chomik, T., Larsen, C, 1996, 'Health impact assessment as a tool for population health promotion and public policy', A report submitted to the Health Promotion Division of Health Canada, Institute of Health Promotion Research, *University of British Columbia*, May 1996: pg. 69.

[6] *The Oxford Dictionary,* (2007)

[7] *The Macquarie Dictionary* (1998)

[8] Frankish, C.J., Green, L., Ratner, P., Chomik, T., Larsen, C, 1996, 'Health impact assessment as a tool for population health promotion and public policy', A report submitted to the Health Promotion Division of Health Canada, Institute of Health Promotion Research, *University of British Columbia*, May 1996.

[9] Wood, L., Giles-Corti, B 2006, 'Social determinants of health: Healthway review', Report prepared for the WA Health Promotion Foundation (Healthway). School of Population Health, *The University of Western Australia,* Perth.

The 2007 SACOSS Blueprint

In 2004/05 SACOSS developed *Extending opportunity to all: A blueprint for the elimination of poverty in South Australia*[10]. Within this document SACOSS determined five main themes that impact upon and contribute to the experience of poverty for individuals and groups within South Australia. In 2007 SACOSS reviewed and extensively updated the document, to produce the *Blueprint for the eradication of poverty in South Australia*. The five main themes are represented in the figure below[11].

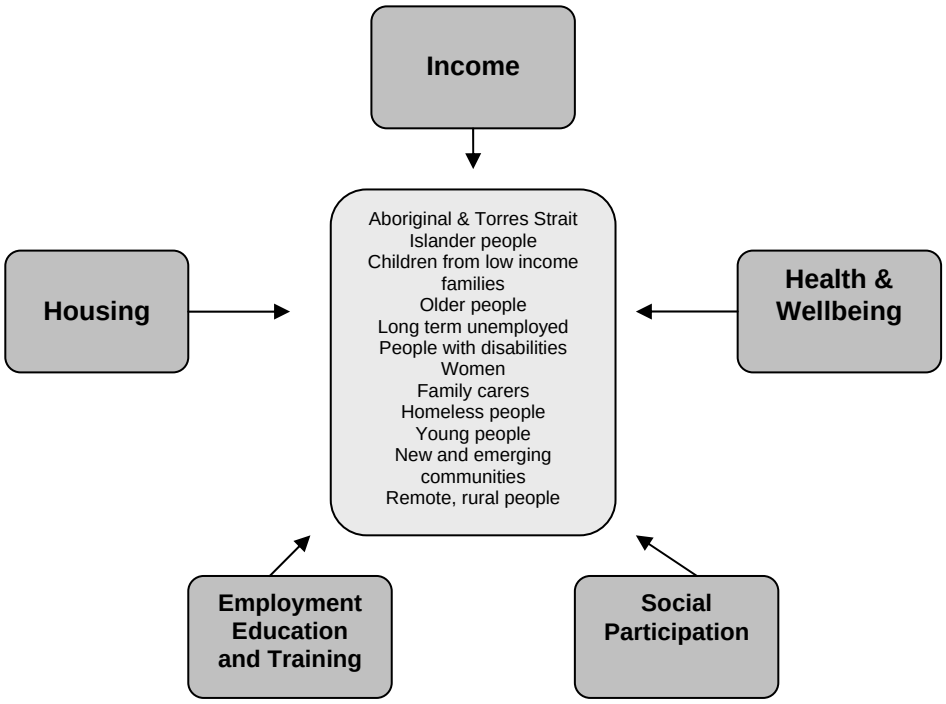

Figure 1: SACOSS approach to understanding poverty and disadvantage

Figure 1 demonstrates the five main themes that SACOSS identified to enable an understanding of poverty and disadvantage. It also demonstrates the main population and social groups who experience poverty and are impacted upon by the social and environmental contributors to poverty[12].

Australia's economy (as part of a global boom) has grown steadily over the last 15 years. During 2001 – 2006 Australia's economic growth averaged 3.0% per year, well above the average for OECD countries during the same period (2.2%). During the same period the Australian economy posted a surplus of 0.9% of gross domestic product (GDP) compared against an average deficit of 2.8% across OECD countries. It is within this environment of unprecedented economic growth we find that in 2006 one in ten Australians were living below the poverty line[13].

In the 2006 Australia Fair report it was found that an estimated 2,210,000 people, or 11.1% of Australians including 412,000 children, lived below the most widely used poverty line measurement

[10] SACOSS, 2005, 'Extending opportunity for all: a blueprint for the elimination of poverty in South Australia, the *South Australian Council of Social Service Inc*.
[11] SACOSS, 2007, 'Blueprint for the eradication of poverty in South Australia', *South Australian Council of Social Service Inc*, December 2007.
[12] *Ibid, p. x*
[13] Australia Fair (2007), 'Australia Fair: Update on those missing out', *The Australian Council of Social Service*

in international research. This poverty line, used by OECD countries, is set at 50% of the median (middle) disposable income for all Australian households. In 2006 this poverty line was set at $281 per week[14]. A less austere poverty line, used in Britain, Ireland and parts of the European Union, is set at 60% of median income for a single adult. In this case the poverty line is set at $298 per week. Using this measure it is estimated that there are 3,859,00 people in Australia (including 786,000 children) living in poverty. It is worrying to note that while the poverty line is set at $298 per week for a single adult most social security payments are well below that figure. Newstart and Austudy are set at just over $200 per week and the aged pension is around $220 per week. Figure 2 demonstrates trends in poverty within South Australia over a 12 year period. The graph demonstrates figures using the 50% and 60% median income poverty line[15]:

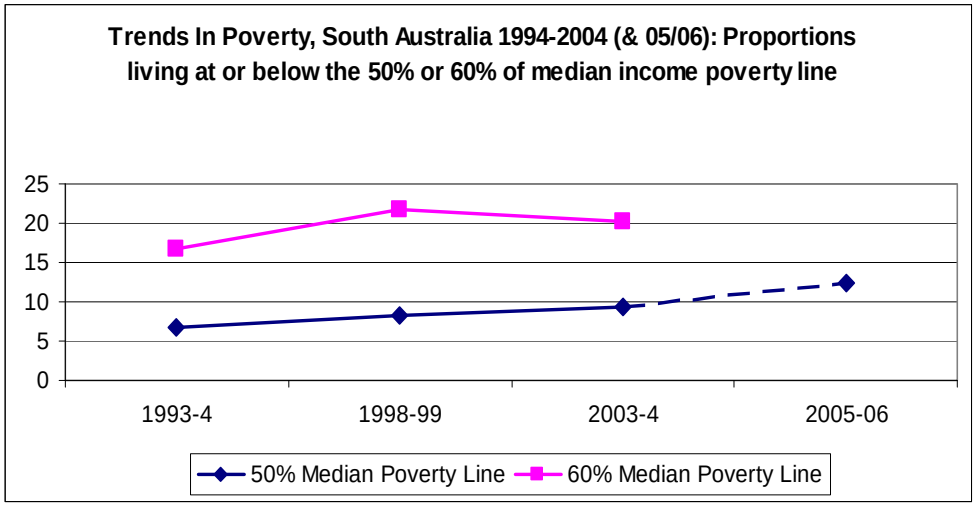

Figure 2: Trends in poverty, South Australia 1994-2004 (& 05/06)
Australia Fair commissioned research by the Social Policy Research Centre, University of NSW. NB: The dashed line on the 50% median income indicator is unpublished data produced by SPRC for Australia Fair.

These statistics demonstrate that poverty is not only still an issue within Australia but it is also steadily increasing.

The South Australian Government has created a target *(South Australia's Strategic Plan Target* T6.5) that seeks to limit economic disadvantage. This target seeks to reduce the number of South Australians whose main source of income is government benefits. However SACOSS is concerned at the lack of traction that this target has received, and the dearth of direct strategies to meet this target[16].

The five main themes contained in the 2007 SACOSS *Blueprint* broadly encompass the key social and environmental determinants impacting on the experience of health felt by all South Australians.

Models to explain the universal determinants of health

So what are the social determinants of health? While it would be easy to be prescriptive, it is important to note that the social and environmental factors affecting our health and wellbeing are

[14] *Ibid, p. 2*
[15] SACOSS, 2007, 'Blueprint for the eradication of poverty in South Australia', *South Australian Council of Social Service Inc*.
[16] *Op cit.*

broad and varied. However there is a set of 'common' elements acknowledged as impacting and influencing our health and wellbeing[17]. Dahlgren and Whitehead's much-replicated Social Determinants of Health Rainbow (Figure 3) demonstrates the layers and interconnectedness of the various sociological, environmental and health related factors that influence our health and perceptions of wellbeing.

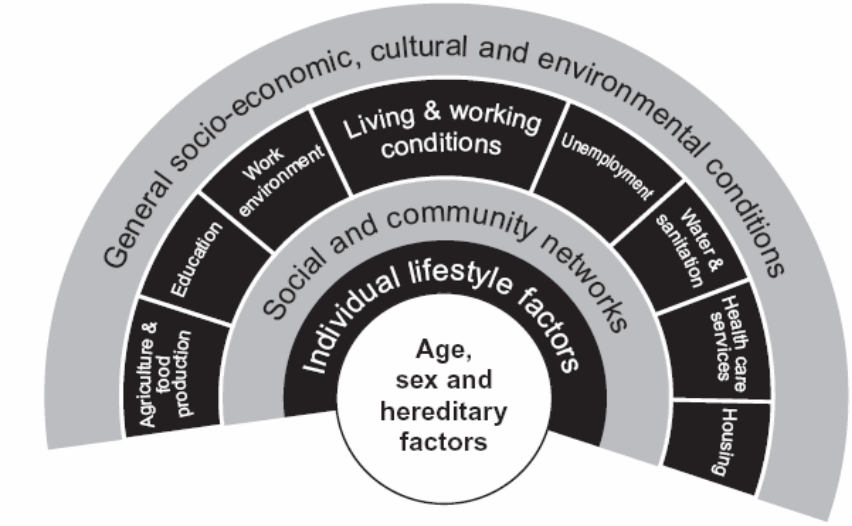

Figure 3: Dahlgren and Whitehead's Social Determinants of Health Rainbow
Source: Dahlgren and Whitehead (1991) cited in Leeds NHS Primary Care Trust, Date Unknown)

These factors are based around:

- Healthy living conditions (including access to food, water and sanitation)
- Education, literacy and health literacy
- Stress
- Early life
- Social exclusion
- Employment & unemployment
- Age, sex and heredity factors
- Culture, racism & discrimination
- Access to information and appropriate health care
- Social supports and access to transport[18].

Many models have been developed by researchers to explain the processes and elements that contribute to the health of our populations. Evans and Stoddart developed a model that built upon the Lalonde Health Field Model, describing health as being determined by sets of complex sets of 'constructs' that relate and interrelate to determine our experience of health and our ability to react to disease and other health problems[19]. Similar to Figure 3, Figure 4 demonstrates the interconnectedness of social, environmental, and personal elements that affect our experience of health and wellbeing.

[17] Australia Fair (2007), 'Australia Fair: Update on those missing out', *The Australian Council of Social Service*
[18] Hetzel, D., Page, A., Glover, J., Tennant, S, 2004, *'Inequality in South Australia: Key determinations of wellbeing'. Volume 1: The Evidence.* Adelaide: Department of Health (SA), 2004.
[19] Bazos, D., Tutko, H., (2006) 'Back to the future: the determinants of health', *Empowering Communities Project*. January 2006, Viewed Online, 15 January 2008.
http://www.nhhealthpolicyinstitute.unh.edu/ec/ppt/06_comm-determinants.ppt

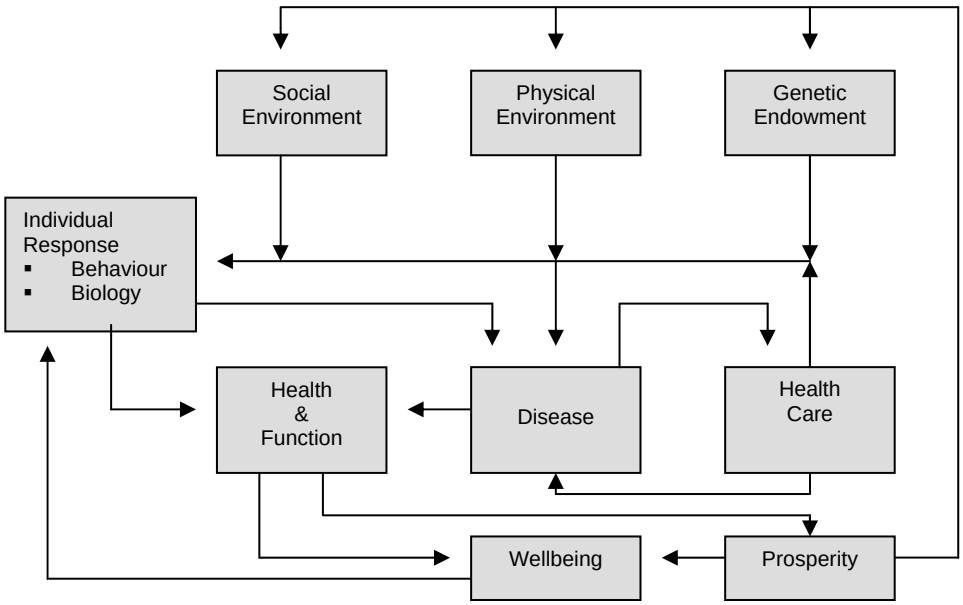

Figure 4: Evans and Stoddart Field Model of Health and Wellbeing
Source: RG Evans & GL Stoddart 1990, cited in Bazos and Tutko 2006.

In Western society, the 'social gradient' is particularly significant in determining health and wellbeing. Social and environmental influences impact notably on the disadvantaged and vulnerable[20].

The social gradient can be explained with the image of a ladder. From the bottom to the top, each rung of the ladder indicates the socioeconomic levels where particular groups sit within society. People who fall into disadvantaged groups, such as indigenous populations and groups from lower socioeconomic areas, are typically found on the lower rungs of the 'ladder'. The social, economic and political environments within which people live influence where they sit on the rungs of the ladder, and whether they are able to move between the rungs[21].

[20] Wood, L., Giles-Corti, B 2006, 'Social determinants of health: Healthway review', Report prepared for the WA Health Promotion Foundation (Healthway). School of Population Health, *The University of Western Australia,* Perth.
[21] *Ibid, p. 9*

The social determinants of health

The social determinants of health, as demonstrated in the Dahlgren and Whitehead model, are researched extensively and are represented within the five sections of the SACOSS *Blueprint*. The *Blueprint* found that experiences of poverty and poor health are inextricably linked. International research has consistently indicated that people from lower socioeconomic groups are more likely to suffer ill health than wealthier citizens. This inequity in health and wellbeing across the social gradient is increasing despite South Australia experiencing a period of economic growth within a larger context of economic growth nationally.

It is also important to delineate between health inequities and health inequalities. Health inequality is seen as describing the difference and variations of health in different groups due to genetics and other physiological factors, whereas health inequities describe differences in health status and the access that people have to health care, due to social differences and social injustice[22].

Evidence on the social determinants of health and wellbeing is mounting. Emerging research makes clear that one of the greatest determinants of our experience of health is income and socioeconomic position. With this in mind it is important to note that the gap between the rich and poor is widening not only in South Australia but across the country[23].

1. Income and social status

The effect on health and wellbeing of an individual's personal income cannot be underestimated. It is known that the greater the level of personal income, the further up the 'social gradient ladder' an individual will be. These individuals generally enjoy better access to health care, nutrition and often live longer than people on the lower rungs of the ladder. Within the upper levels of the social gradient other social outcomes such as education, literacy and coping behaviours are overrepresented[24].

Living in poverty has been established, both anecdotally and empirically, as a significant social determinant of health. Social and economic disadvantage impacts upon people throughout the life cycle, with those further down the social gradient having double the risk of serious illness and premature death as those on the upper rungs[25]. This experience of hardship and the effects of social exclusion which often accompany the experience of poverty have been correlated with unhealthy lifestyle choices, food illiteracy, stress, anxiety and a decline in positive health status[26].

A study by Kaplan et al[27] found that variations in income distribution were significantly connected with various negative health outcomes including increased rates of mortality and higher rates of behavioural risk factors (such as poor diet, smoking, excess alcohol consumption and other forms of substance abuse). This was further substantiated in a study by Kawachi, which convincingly established not only a connection between low levels of income and chronic diseases such as heart disease, malignant cancers, and infant deaths, but also correlated these factors to low levels

[22] Wood, L., Giles-Corti, B 2006, 'Social determinants of health: Healthway review', Report prepared for the WA Health Promotion Foundation (Healthway). School of Population Health, *The University of Western Australia,* Perth.
[23] South Australian Council of Social Service Inc, 2007, 'Blueprint for the eradication of poverty in South Australia', *SACOSS*.
[24] *Ibid, p. 58*
[25] Marmot, M and Wilkinson, R (Eds) 1999, *Social Determinants of Health*, Oxford University Press, Oxford; Wilkinson, R and Marmot, M 2003, *Social Determinants of Health: The Solid Facts. 2nd edition*, World Health Organisation, Denmark.
[26] Menadue, J. 2003, 'Better Choices, Better Health: final report of the South Australian Generational Health Review, Government of South Australia, April 2003
[27] Kaplan, G., Pamuk, E., Lynch, J., Cohen, R., Balfour, J 1996, 'Inequality in income and mortality in the United States: an analysis of mortality and potential pathways', in *BMJ Journals*, vol. 312, pp. 999-1003.

of social participation and community connectedness[28]. The social gradient and the effects that income, advantage and social participation have over the experiences of health and wellbeing is a disparity demonstrated and replicated across society[29].

In addition, the 2003/04 Household Expenditure Survey[30] demonstrated that the increase in average weekly household expenditure on goods and services between 1998/99 and 2003/04 was $184 or 26%. Over the same period, the cost of goods and services, as measured by the CPI, rose by 18%. These statistics can be further broken down into the categories of household expenditure that impact upon income such as:

- Weekly expenditure rose by $38 (39%)
- Increased mortgage interest payments rose by $12 (47%)
- Increased rent payments, up by $9 (23%)
- Food and non-alcoholic beverages, up by $26 (20%)
- Recreation, up by $24 (27%)
- Transport, up $21 (18%), with increases in the purchase of both motor vehicles and petrol (16% and 26% respectively)
- Interest payments on credit services up by $8 (79%)
- Health practitioners' fees up by 44%
- Education fees up by 41%
- Child care up by 34%

The perpetual rising costs of day to day expenditure increases the pressure on the disadvantaged every day which compound over a lifetime on their physical and psychological health[31] [32].

Despite the dearth of empirical data exploring the extent of financial exclusion within Australia, it can be confidently hypothesised that a high level of financial exclusion exists among the bottom income quintile (the bottom rung/s of the social gradient ladder)[33].

2. Social participation and social support networks

Income levels and experiences of financial and social exclusion intersect and interact within the experience of poverty. Social exclusion is the outcome of a loss or lack of connection to the community in which you live. Four main elements of social exclusion have been identified:

- *Consumption* – the incapacity to purchase goods and services relative to need.
- *Production* – A lack of participation in economically or socially valued activities.
- *Political engagement* – A lack of participation within government processes (local, state, federal decision making).
- *Social interaction* – A lack of connectedness to family, friends and the community in which you live.

Increased social interaction and participation within one's community/ies perpetuate a sense of belonging and social connectedness that has been convincingly linked to positive physical and psychological wellbeing. Conversely, an equally important correlation has been established

[28] Kawachi, I., Kennedy, B., Lochner, K., Prothrow-Stith, D, 1997, 'Social capital, income inequality and mortality', in, *American Journal of Public Health,* vol. 87, no. 9, pp. 1491-1498.
[29] Wilkinson, R and Marmot, M 2003, *Social Determinants of Health: The Solid Facts. 2nd edition*, World Health Organisation, Denmark
[30] Australian Bureau of Statistics, 2005, 'Household expenditure survey: summary of results – 2003-04', viewed 28 June 2007. <http://www.abs.gov.au>
[31] Payne, S 1999, 'Poverty, social exclusion and mental health: findings from the 1999 PSE survey, working paper No. 15, Townsend Centre for International Poverty Research, University of Bristol.
[32] Ibid & Weich, S., Lewis, G., Jenkins, SP 2001, 'Income inequality and the prevalence of common mental disorders in Britain', in, *British Journal of Psychiatry,* vol. 178, pp. 222-227.
[33] Wilson, D 2002 *Pay day lending in Victoria: a research report*, Consumer Law Centre Victoria Ltd, p 50.

between decreased social participation and negative consequences for physical and mental health. This experience of social exclusion is characterised by smaller social networks, fewer close relationships and reduced social supports[34].

3. Education

A sound education provides the foundations for the future ability to make choices regarding our occupation, thereby giving us greater influence and control over our future levels of income, where we will live, and also over the various factors that influence our health and wellbeing across our lifespan[35]. A high level of education equips individuals with the skills to cope with day to day challenges, and further enables individuals to participate more fully within the employment market, the economic market, and their communities[36]. Over recent years, much international public debate regarding global inequity has centred upon the 'digital' divide (or technology divide). The level of education attained by individuals is inextricably linked to the social gradient[37]. It is considered quite problematic that industrialised nations, comprising only 15% of the world's population, command 88% of internet usage. The divide between those who have access to information technology and those who don't is undoubtedly an inequitable situation — however what is sometimes forgotten within these debates is that many of these technologically excluded countries have not as yet experienced the 'education age'. The global population who have not yet experienced the education age amounts to nearly one billion[38].

A recent survey by the Australian Bureau of Statistics[39] showed alarming results regarding the literacy skills of Australians. The survey found that:

- Only just over half (54%) of Australians aged 15 to 74 years were assessed as having the literacy skills needed to meet the complex demands of everyday life and work.
- Out of this figure, women had higher scores for prose and health literacy, while men had higher scores for document literacy and numeracy.
- Across all the different types of literacy, people who were employed were more likely to be assessed as having the skills necessary to meet the complex demands of everyday life and work than were unemployed people or those not in the labour force[40].

4. Health literacy

Inextricably linked to the notion of health literacy is our experience of education. Education (and literacy) is one of the key social determinants of health. A useful and broad definition of health literacy provided by Nutbeam 1998[41] states:

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[34] Kawachi, I., Berkman, L.F. 2001, 'Social ties and mental health', in *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* vol. 78, no. 3, pp. 458-467.

[35] Hetzel, D., Page, A., Glover, J., Tennant, S, 2004, *'Inequality in South Australia: Key determinations of wellbeing'. Volume 1: The Evidence.* Adelaide: Department of Health (SA), 2004.

[36] Frankish, C.J., Green, L., Ratner, P., Chomik, T., Larsen, C, 1996, 'Health impact assessment as a tool for population health promotion and public policy', A report submitted to the Health Promotion Division of Health Canada, Institute of Health Promotion Research, *University of British Columbia*, May 1996.

[37] Hetzel, D., Page, A., Glover, J., Tennant, S, 2004, *'Inequality in South Australia: Key determinations of wellbeing'. Volume 1: The Evidence.* Adelaide: Department of Health (SA), 2004.

[38] Kickbusch, I, 2001, "Health literacy: addressing the health and education divide', in *Health Promotion International,* Vol. 16, No. 3, pp. 289 – 297.

[39] Australian Bureau of Statistics, 2006, 'Australia's literacy and life skills', Media Release, November 28th 2007, viewed 3 March 2008.
<http://www.abs.gov.au/AUSSTATS/abs@.nsf/mediareleasesbyReleaseDate/C9661715BFC934D4CA2573A0001A5AE6?OpenDocument>

[40] *Ibid.*

[41] Cited in Nutbeam, D, 2001, 'Health Literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century', in *Health Promotion International*, Vol. 15, No. 3. pp. 259 – 267.

"Health literacy represents the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health".

"Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment".

These definitions indicate the broad personal and social benefits of health literacy where being health literate does not end with the ability to read health related information and attend doctor's appointments. Health literacy is more closely related to the ability to critically analyse one's own experience of health within the larger context of health related knowledge. Being literate and health literate is a form of social empowerment[42].

Being health literate allows individuals to[43]:

- Improve their knowledge regarding health related information
- Make informed decisions regarding their personal health
- Raise their own awareness of the social, environmental and economic determinants of health
- Read medicine labels and instructions
- Read and understand health promotion information
- Act upon necessary procedures and directions given my medical personnel as well as appointment schedules.

Health literacy is crucial for consumers to access, understand and utilise health related information[44], make informed choices regarding their personal health and to contribute to the empowerment of people and communities to self manage health practices[45]

5. Healthy Living Conditions

People's living conditions can have a significant impact on their experience of health and wellbeing. The cost of housing, particularly the cost of privately renting suitable housing, has a major impact on the disadvantaged. Figures released from the 2006 Census[46] reflect the gravity of the housing crisis within Australia. Statistics collected over the periods 1996, 2001 and 2006 from an ABS housing survey demonstrated that in 1996 61 respondents with an income of $250 - $349 were paying the median rental cost of $180-$224 a week. This figure had increased to 1,797 respondents by 2006. Rents are steadily increasing along with other cost of living factors (fuel, utilities, food, etc) and people on low incomes, including government benefits, are finding it exceedingly difficult to exist financially within our society.

Access to nutritious food and clean drinking water is also vitally important for people's health and wellbeing, particularly in early life. Access to nutritious food is impacted upon by levels of food literacy and also by geographical and socioeconomic location. Within many disadvantaged communities, retail outlets selling affordable and fresh nutritious food are often underrepresented. In contrast, processed food (fast food) outlets are often clustered within lower socioeconomic

[42] Nutbeam, D, 2001, 'Health Literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century', in *Health Promotion International*, Vol. 15, No. 3. pp. 259 – 267.
[43] Kickbusch, I, 2001, "Health literacy: addressing the health and education divide', in *Health Promotion International,* Vol. 16, No. 3, pp. 289 – 297.
[44] Green, J, 2007, 'Health literacy: terminology and trends in making and communicating health related information', in *Health Issues 2007*, Number 92, pp. 11-14.
[45] Kickbusch, I, 2001, "Health literacy: addressing the health and education divide', in *Health Promotion International,* Vol. 16, No. 3, pp. 289 – 297.
[46] Commonwealth of Australia, 2006, 'Weekly rent by dwellings, count of occupied private dwellings being rented (b): time series statistics (1991, 1996, 2001), viewed 28 June 2007. www.abs.gov.au

areas. A shortage of food and a shortage of a variety of healthy food are known to contribute to the development of deficiency diseases and increased morbidity[47].

Access to clean drinking water is still an issue, particularly within rural and remote Aboriginal and Torres Strait Islander communities. While the situation for these communities has improved from 15-20 years ago there are still Aboriginal and Torres Strait Islander communities lacking basic water, electricity and sewerage services[48].

6. Racism, discrimination and culture

It is argued that the land and access to the land is a key determinant of health and wellbeing for Aboriginal and Torres Strait Islander people. The systematic displacement of Aboriginal and Torres Strait Islander people from the land since colonisation has engendered cultural disruption, social exclusion, increased feeling of stress, decreased sense of identity, political and social oppression and a loss of control over lives and livelihoods[49]. It is known that Aboriginal and Torres Strait Islander people are more likely to live in overcrowded and unacceptable housing conditions, smoke tobacco, drink to excess, try illicit drugs, have poor nutrition and have higher levels of obesity[50].

The impact of colonisation has created a social and personal environment of crisis in which Aboriginal and Torres Strait Islander people spend much of their lives[51]. Further, Aboriginal and Torres Strait Islander people in Australia have a greater likelihood of suffering from ill health than other Australians. They die at a younger age in addition to experiencing disability and a reduced quality of life at greater rates than other Australians. In 2001 the median age for Aboriginal and Torres Strait Islander Australians was 21 years, in marked contrast to other Australians' median age of 36 years. The life expectancy rates of Aboriginal and Torres Strait Islander Australians demonstrate another disparity: 59 years for males, 65 years for females. Comparison to the average life expectancy rate for all Australians over the same period (77 years for males, 82 years for females), reveals a disparity that is a glaring indictment of health inequity in Australia[52].

The racism and discrimination that has accompanied colonisation and exists to this day is known to impact upon stress levels and contributes to greater feelings of social exclusion. Racism contributes to:

- Reduced or unequal access to employment, adequate housing, education, medical care, social support and social participation.
- Negative emotional reactions that contribute to stress and mental ill health. This also adversely impacts upon the endocrine and cardiovascular systems.
- Use of substances such as tobacco, alcohol and other drugs
- Physical manifestations of racism such as physical assault, intimidation etc[53].

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[47] Wilkinson, R and Marmot, M 2003, *Social Determinants of Health: The Solid Facts. 2nd edition*, World Health Organisation, Denmark.

[48] Ring, I., Brown, N, (2002) 'Indigenous health: chronically inadequate responses to damning statistics', in *The Medical Journal of Australia,* 177 (11), pp. 629-631

[49] Commission on Social Determinants of Health (2007), 'Social Determinants of Indigenous Health: The International Experience and its Policy Implications', *International Symposium on the Social Determinants of Indigenous Health Adelaide*, 29-30 April 2007.

[50] Australian Institute of Health and Welfare (2006), 'Australia's Health: the tenth biennial health report of the Australian Institute of Health and Welfare', Viewed 23 April 2008. www.aihw.gov.au/publications/aus/ah06/ah06.pdf

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[52] Australian Institute of Health and Welfare (2006), 'Australia's Health: the tenth biennial health report of the Australian Institute of Health and Welfare', Viewed 23 April 2008. www.aihw.gov.au/publications/aus/ah06/ah06.pdf

[53] Paradies, Y., Harris, R., Anderson, I, (2008) 'The Impact of Racism on Indigenous Health in Australia and Aotearoa: Towards a Research Agenda', Discussion Paper Series No. 4, Cooperative Research Centre for Aboriginal Health, Viewed 23rd April 2008, www.crcah.org.au/publications/downloads/Racism-Report.pdf

For people from cultural and linguistically diverse backgrounds (CALD), issues such as racism and discrimination and their experience of health are also present but in different ways. Refugees may have experienced threats to their lives, wars, loss of family members, loss of community and homeland, culture, traditions, employment and changes to family roles. Many of these people come to Australia knowing limited, if any, English and are placed within communities to which they have no connections, and with no support networks. The language barrier, in addition to racism and discrimination, can place significant pressure on individuals while also creating barriers to adequate health care, education, social inclusion, employment and social support[54].

7. Early life factors and genetics

In our early life we are exceedingly vulnerable to risks that can potentially impact upon us throughout our lives. This is particularly true of our experience of health and wellbeing[55]. The quality and appropriateness of the environment in which a child lives from birth until early childhood determines their level of brain stimulation and brain development. Brain development is vital to school performance and achievement, and is considered to set the parameters of the child's economic, social, educational and health related outcomes as an adult[56].

Genetic inheritance, gender, growth, aging and the functioning of individual physiology are influential in determining an individual's experience of health and wellbeing. Genetic inheritance transcends commentary regarding health inequity and is a demonstration of 'health inequality'[57].

8. Individual behaviours and lifestyle factors

The individual behaviours and lifestyle choices that we make for ourselves are markedly influenced and impacted upon by our education, literacy levels, inclusion within society and socioeconomic position. Factors such as smoking, drinking and using illicit drugs are obvious choices that individuals make that impact greatly on their experience of health and wellbeing both in the short and longer term. The decision to use tobacco, alcohol and/or illicit drugs is often socially patterned by an individual's socioeconomic position. In fact, smoking behaviour is connected to the social gradient with people on the lower rungs of the gradient having the poorest smoking related health outcomes[58].

9. Access to health care

Access to appropriate and linked health services impacts greatly on the experience of health and wellbeing, particularly on those disadvantaged from birth. Access to appropriate primary health care facilities is vital in offering preventative health care services, including baby immunisation and targeted health promotions[59]. It is also important to remember that services have a responsibility to ensure they identify and mitigate barriers to access.

According to the Australia's Health report (2006), from the Australian Institute of Health and Welfare, people who live within disadvantaged areas are still overrepresented in mortality and morbidity figures. The report found that in 2000–2002, infants living in the most disadvantaged areas of Australia had double the death rate of those in the more advantaged areas. During

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[54] Kakakios, (Date Unknown), 'The Provision of Health Care in a Culturally Diverse Community' *Primary Health and Community Partnerships Branch NSW Department of Health,* viewed 23 April 2008. www.health.nsw.gov.au/futuresplanning/pdf/culturally_diverse_community.pdf

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[57] Hetzel, D., Page, A., Glover, J., Tennant, S, 2004, *'Inequality in South Australia: Key determinations of wellbeing'. Volume 1: The Evidence.* Adelaide: Department of Health (SA), 2004.

[58] *Ibid*

[59] Hetzel, D., Page, A., Glover, J., Tennant, S, 2004, *'Inequality in South Australia: Key determinations of wellbeing'. Volume 1: The Evidence.* Adelaide: Department of Health (SA), 2004.

childhood, the same comparison showed that 75% of boys and 46% of girls had higher mortality rates than children from wealthier areas. The report also states that in 1998–2000, the mortality rate for males living in lower socioeconomic areas was 80% higher overall than for males living in wealthier areas. For females the rate was 50% higher. In addition, people from lower socioeconomic areas aged 25–64 years are more likely, compared with those in more advantaged areas, to assess their health as poor or only fair, drink alcohol at harmful levels, smoke, be obese, and suffer from hypertension[60].

The booking lists for non-urgent surgery in South Australia reveal that people from Adelaide's most disadvantaged areas are overrepresented on surgery waiting lists. In 2002 people from disadvantaged areas were twice as likely to be represented on waiting list as people in more advantaged areas. This is demonstrative of the effects disadvantage has on the health of individuals and on access to health services in lower socioeconomic areas[61].

Implications for health promotion

The health care of South Australians is often a convoluted set of competing priorities and perspectives: from the individual, across local, State and Federal governments, to health care professionals and the health care system. Nationwide, the health sector costs Australia over 9% of its gross domestic product, which equates to over $3,500 per person per year. This figure can be compared with 8.7% of GDP in 1998/99 and 8.1% in the early 1990s[62]. It is in the best interest for governments to strategically target the causes of illness to ameliorate them as part of a prevention and early intervention focus.

It is recognised that health promotions have customarily focused upon behavioural risk factors amongst target groups to raise awareness or ameliorate negative health, but increasingly health promotions and interventions are being asked to consider the larger sociological context in which health inequities exist. By addressing the underlying causes of ill health, a preventative and early intervention focus can be achieved. There is increasing recognition of the need for Australia to embark upon research investigating the social factors that contribute to the determinants of health and the experiences of health and wellbeing, particularly on disadvantaged groups. Overseas research, particularly within the UK and Canada, has been instrumental in identifying public health inequities which have informed and contributed to health promotions, strategies, interventions and policy changes. Studies have shown that the role for health promotions in relation to improving the social determinants of health in disadvantaged groups can include advocacy, partnerships with other sectors and becoming an agent of change in a 'whole of government' strategy[63].

Implications for research focus

While there is considerable explanatory research on the social determinants of health, more research is needed regarding the pathways through which the social determinants affect health. This research will then be able to become synthesised with strategy development and policy implementation[64]. Research is also needed to provide evidence to guide interventions, such as policy or legislative changes, that are likely to be effective in addressing the social determinants of health and hence enhancing health and wellbeing in the Australian population.

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[60] Australian Institute of Health and Welfare, 2006, 'Australia's Health 2006: the 10th biannual health report of the Australian Institute of Health and Welfare', Canberra, AIHW Cat. No. Aus 73. Viewed 4 February 2008. http://www.aihw.gov.au/publications/aus/ah06/ah06.pdf

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[62] Australian Institute of Health and Welfare, 2004, 'Australia's Health 2004: the 9th biannual health report of the Australian Institute of Health and Welfare', Canberra, AIHW Cat. No. Aus 44. Viewed 4 February 2008. www.aihw.gov.au/publications/aus/ah04/ah04-050222.pdf

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Summary

For the disadvantaged, social impediments perpetually deny access to the elements that positively contribute to our health and wellbeing. This exclusion has been convincingly linked to negative health effects (both physical and psychological) and early mortality.

Significantly, there have been many useful experiential studies elucidating the link between the social contributors of health and negative health effects for the disadvantaged. Importantly it is known that the effects of this disadvantage affect individuals not only from birth throughout adulthood, but have also been linked to generational disadvantage. Recognition of the negative health effects of the social determinants of health are being embraced by government and are beginning to inform social and health related policy.

In conclusion, government clearly has a role to play in ameliorating the social impediments of health and wellbeing. Holistic (whole of government) strategies need to be developed and implemented that seek to address the social inequity that contributes to both the social gradient and negative health effects. Presently, many of these steps are being undertaken in South Australia through health promotion and addressing structural inequality. However, as statistics show us that the experience of poverty is growing both nationally and in South Australia, this disadvantage will compound and result in further experiences of ill health amongst the most disadvantaged groups.

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