TAKING RESPONSIBILITY TO ADDRESS INEQUALITIES IN HEALTH

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For many people, access to the prerequisites for health outlined in the preamble to the Ottawa Charter: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity, continues to be a distant dream.[1] Despite 'major efforts by governments and international financial institutions in the latter half of the twentieth century to reduce poverty, primarily by promoting economic growth, we have more poor people today than when we started'.[2] Many of the population health gains that have been achieved over the past 150 years are in danger of being reversed. This article describes ways in which public health practitioners can take a greater personal responsibility for reducing inequalities in health.

CHALLENGING THE 'INEVITABILITY' OF GLOBALISATION

Current economic theories that drive globalisation regard unemployment, insecurity, a declining sense of wellbeing, and the erosion of 'social capital', not as evils to be fought against but at best as side effects to be treated by social policy, or at worst as levers to discourage resistance by wage earners.[3] Current economic and social policies have redistributed national incomes in favour of profits to individual shareholders; strengthened the grip of private investors on the economy; and limited policy choices to those that have been approved by the financial markets. Economic policy choices are based on a value system that undermines the notion that public expenditure is an *investment* in education, health care, public health, welfare, employment creation, or even infrastructure such as roads. Instead, the underlying value system regards public services simply as *expense*.[2]

On the other hand, there are examples of globalisation working positively, through the combination of communication technologies and greater numbers of literate men and women, and through the consequent democratisation of knowledge. Hartigan pointed out that 'this explosive spread of information and knowledge drove the winds of democratisation throughout most of Latin America in the 1980s to overthrow autocratic governments. It contributed to the fall of communism in the 1990s and supports now both a rising awareness of what our pattern of production and consumption is doing to the environment and a heightened sensitivity to the inequalities that continue to limit the choices and opportunities available to men and women in different parts of the world'.[3]

Like Stilwell in the preceding article, Kelsey challenges the notion that the directions being taken by economic globalisation are inevitable and irreversible, pointing out that they result from decisions made by individuals and organisations.[4] It is possible to make alternative decisions to achieve different goals based on different values.

If we are to succeed in reducing inequalities in health, it is vital to harness the positive aspects of globalisation. There is a growing body of knowledge about actions that could and should be taken by governments and organisations to bring about reductions in social and economic inequalities; and therefore a reduction in health inequalities. Recent examples can be found in Australia, the United Kingdom, North America, and other countries.[5,6,7,8]

CONTRIBUTING TO THE SOLUTION: WORKING GLOBALLY

Multiple organisations and individuals are working to change the goals and directions of globalisation: economic, social and environmental. For example, the World Bank has been influenced to establish a major initiative in poverty reduction, and the decisions made by the World Trade Organization are now under intense scrutiny. A recent meeting of non-government organisations in Genoa canvassed specific methods by which less powerful people, organisations, and governments can participate equally with the more powerful in decision-making about world trade.[9]

CONTRIBUTING TO THE SOLUTION: WORKING NATIONALLY

Labonte points to the importance of working through our own government by suggesting that, while we may need to establish global governance for the common good, 'we may need even more to reduce the need for such governance by ensuring our national-level efforts are maintained, if not increased. The health (and social and environmental) inequalities arising from globalisation are not caused by globalisation per se. They are phenomena of national-level forms of economic and political organisation. Globalisation, through structural adjustment programs and the World Trade Organization, merely extends this organisation globally, reducing the ability of civil society groups to maintain healthy compromises between state and market control, or to challenge unhealthy forms of economic and political practices, within their own borders'.[9] The nation-state still matters.

CONTRIBUTING TO THE SOLUTION: WORKING INDIVIDUALLY

When considering 'what can I do as an individual?' the first step is to be clear about the extent to which it is *our* governments, *our* institutions and organisations, and *our* decisions that create the conditions that determine the health of populations. It follows that the

action that can be taken and should be taken to address the determinants of health is within *our* capacity to take—individually as well as collectively. This does not mean it is easy.

It is easy, however, to feel that individual efforts amount to little given the scale of the problem. It is also true that some of the reluctance to act is because of a perceived need for more evidence before acting. There is now overwhelming evidence describing social, economic and health inequalities, and about many of their determinants. There is also some evidence of ways to address these—although much more evidence is needed. The challenge confronting individuals is to do what we can with the knowledge we have. The alternative to doing is waiting: for others to act, for more information, for an invitation to participate.

The ideas outlined below represent an attempt to bridge the gap between what should in general be done and what individuals can do.

Establish the reduction of health inequality as a national goal

Reducing preventable inequalities in health across and between populations should be a principal goal of governments, of the health sector and other sectors, and of individual public health practitioners. Much current policy assumes that through economic growth all people will become not only wealthier but also healthier. However, in Australia, as elsewhere, there appears to be limited concern about the growing inequalities in the distribution of wealth and health in the population.

A first step to reducing health inequality is the establishment of a national goal making equality of access to economic, social and environmental resources an outcome for which government is responsible to the public. This goal sets a policy framework for action, and accountability for progress; and highlights priorities for the investment of resources.

Becoming informed as a health practitioner: what and how

Every health practitioner should learn about:

- the determinants of health;
- the theories, policies and practices that are leading to increasing inequalities in health;
- alternatives that could guide the policy decisions of governments and organisations;
- how to influence decision-making, through learning about the governance and structures of organisations, and about processes used to set agendas and make decisions;[12]
- how other individuals engage in the process of bringing about change. There are significant and influential constituencies in all nations that recognise

the need for global cooperation, leadership from international organisations, venues for debate and advocacy, and the exchange and monitoring of information;
- the many perspectives on what constitutes 'progress' for different countries, different communities, and different individuals;[10,11]
- the World Wide Web and its potential to bring about social and economic change.

Taking action

Because public policy is the outcome of decisions made by individuals, the challenge for public health practitioners is to become a more active part of this process as individual members of different groups.

Many of us work in or manage academic institutions and service-delivery organisations that have the power to set goals and to act to reduce inequalities in health. Many of us are members of professional associations such as the Public Health Association of Australia, the Australian Health Promotion Association, the Australian Medical Association, and the Australian Nurses' Federation; or we belong to community organisations such as Parents and Citizens', a sporting club, or a church. All of these associations and organisations represent constituencies that can influence the decisions of governments in relation to public health policy and practice. They also offer opportunities to collaborate with other individuals and groups who are concerned to reduce inequalities—within Australia and globally.[13]

If we do not act, who will?

Individuals should take every opportunity to act to reduce inequalities. It is not necessary to work on a large scale; but it is important to act within many individual spheres of influence. We can belong to different constituencies, and we can make every effort to influence the decisions of policy-makers. The challenge is to ensure constant vigilance, and to ensure that our actions are contributing to the solution rather than to the problem.

None of the ideas presented below are new. They recall the earlier days of the women's movement in the 1970s when women acted to overcome exclusion from full participation in public life. They also reflect the methods used by gay men to bring about action to address the threat of HIV–AIDS; and by environmentalists to draw attention to the effects of unrestrained markets on the environment.

Because the voices for equality and social justice have been fragmented, it is necessary to mobilise advocacy in new ways as well as old. Global communication technologies, including the World Wide Web, make activism possible on a wide scale. The protests at meetings of the World Trade Organization have been reminders of the power of community mobilisation.

International efforts by groups of individuals have succeeded in forcing pharmaceutical companies to waive their patents to allow developing nations a greater access to cheaper drugs to combat the HIV–AIDS epidemic.

In relation to health inequalities, the role of the public health practitioner seems to have been confined to that of describing the problem and its determinants, although policy solutions are being proposed.[14] To ensure that these policies are implemented, however, means becoming and staying informed about policy-making and implementation processes. It means using this information ourselves and with our communities. Public health practitioners can do this by:

Becoming more ambitious within our own organisations

As individuals we must ensure that we are key players in setting agendas, and in developing and implementing health policy. We need to move in from the margins and become central players within the health system. More than eight per cent of Australia's gross domestic product is invested in the health sector,[15] and the health sector employs approximately eight per cent of the Australian workforce. This is an enormous sector with great influence, and capacity to reduce health inequalities lies, in part, within the health sector itself.

For example, as a health service manager:

- Does your health service state explicitly that its goal is to contribute to reducing inequalities in health?
- Do you actively seek to build relationships with members of disadvantaged groups to assist in making decisions about priority services?
- Does your service actively seek to employ members of disadvantaged or disenfranchised groups across all levels of the organisation?
- To what extent do you provide support and career development opportunities for such groups?
- To what extent do you report on progress in reducing inequalities directly to the community?
- To what extent do you support and encourage debate on these issues among staff?

Working closely with communities—particularly with those who are most marginalised

We need to build constituencies for change, capacities to act, and systems for active participation.[13] This is much more likely to occur through membership of and participation in community organisations or activities than through our professional roles. Communicating with fellow parents, with other members of the branches of our political parties, with members of the golf club, with members of our churches, or with the local health action group, is likely to be as powerful as formal, official communication.

For example, as a member of a Parents and Citizens' committee or sports club:

- Do you 'know' the members of your Committee?
- What active measures are taken to encourage and support membership by disadvantaged groups?
- What active measures are being taken by your school to encourage and support children whose families are poor and not well educated to complete their education?

Moving into other sectors

Influencing the policies, programs and services provided by sectors other than health is clearly one of the keys to reducing inequalities in health. Working in partnership with other sectors is obviously important. But working from within sectors such as education, agriculture, trade and treasury is equally vital. Further, seeking to influence the curricula for undergraduate and continuing education for all professionals is a powerful role for academics, as is conducting relevant intervention research.

Actively participating in professional organisations

If you are a member of a professional association:

- Do you know the backgrounds of the members of your Board or Executive?
- Do you know the interests of your fellow members?
- What are the goals of your organisation, and to what extent do they contribute to reducing inequalities in health?
- Does the organisation have a working group focusing on action to enhance the organisation's contribution to reducing inequalities in health?
- What opportunities are there for members to be informed about the issues and to debate solutions? Are there regular opportunities for communication and action planning with members of disadvantaged groups? Are decision-makers from sectors other than health regularly invited to speak at conferences and workshops?
- To what extent does your organisation advocate directly, and with partner organisations, to influence the decisions of managers, politicians, and international agencies?

CONCLUSION

It will be impossible to reduce inequalities in health if individuals do not act to influence the goals and directions of globalisation. The role of public health practitioners and their professional networks will then be reduced to that of describing and alleviating the effects of inequality on the health of populations, and we will find ourselves continuing to respond to the problem rather than influencing its causes. Building evidence and developing professional solutions are important; but so are personal and political activism.

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HOW CAN A GOVERNMENT RESEARCH AND DEVELOPMENT INITIATIVE CONTRIBUTE TO REDUCING HEALTH INEQUALITIES?

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The Health Inequalities Research Collaboration (HIRC) is a research initiative to address health inequalities, established in July 1999 by the Commonwealth Minister for Health and Aged Care. Its ability to offer policy options to the government, like similar initiatives in other countries, is circumscribed by numerous factors. They include lack of consensus about the causes of health status differentials, inadequate evidence on how to intervene to reduce health inequalities, and an infrastructure that is underdeveloped in terms of intersectoral action. This article reflects on the work done during the first eighteen months of the Collaboration; on the dynamics that need to be accounted for in any research and development (R&D) response to persistent and growing health inequalities; and on some opportunities offered by the Collaboration in meeting these challenges.

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* *The views expressed in this article are those of the authors alone and do not represent the views of the Health Inequalities Research Collaboration Board.*

BACKGROUND

In spite of increasing government expenditures on health systems, health differentials are increasing in many countries. In Australia, health inequalities grew in the 1990s in relation to particular diseases such as type 2 diabetes and circulatory system diseases.[1] Much of the explanation of increasing social gradients in health is focusing on factors in the social environment. Indeed the uneven distribution of behavioural risk factors is argued to result from the uneven—some would say unfair—distribution of economic and social resources; and opportunities such as income, employment, social capital, social support and control in the workplace. In some circles, smoking, drinking too much alcohol and being overweight are explained as individual responses to the absence of resources such as these.[2–3]

Still, there is much speculation and relatively little evidence about how factors in the social environment, often referred to as social determinants, have an effect on health status. As a result, the Commonwealth Government