4

Tackling health inequalities

REDUCING SOCIOECONOMIC HEALTH INEQUALITIES: ISSUES OF RELEVANCE FOR POLICY

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BACKGROUND

During the twentieth century, the health of the Australian population improved markedly: life expectancy increased; the toll of communicable disease was reduced; and, in more recent times, death rates for cardiovascular disease and a number of major cancers have begun to decline.[1,2] However, against this backdrop of improving overall health, large health inequalities continue to exist between socioeconomic groups;[3,4] and, for some conditions, these inequalities are increasing over time.[5] Table 1 illustrates that, despite substantial reductions in age-standardised death rates between 1985–87 and 1995–97, the size of the mortality gap between the most and least disadvantaged areas (indicated by the rate ratio) widened for many conditions. Further, the excess mortality figures show that the burden of death in Australia attributable to socioeconomic inequality is large, and that substantial improvement in this country's national health profile would occur if mortality rates for all areas were equivalent to those of the least disadvantaged areas. This article presents a general discussion of the issues that need to be considered as part of the development and implementation of policies and interventions that are aimed at narrowing the health gap between socioeconomic groups, and halting the widening of mortality differentials.

A reference point for the discussion is evidence from studies that have investigated the main causes of health inequalities.[3] This evidence is summarised in Table 2, where each cause is positioned according to whether it represents an upstream (macro), midstream (intermediate), or downstream (micro) determinant of disease. As the ordering and flow of the evidence suggests, illness and disease are ultimately a consequence of adverse biological reactions (for example: hypertension, fibrin production, and suppressed immune function) that occur as a result of changes or disruptions to the functioning of various physiological systems (for example: the endocrine and immune systems). Thus, the poorer health of disadvantaged social groups is due to more sustained and/or longer term adverse changes to physiological and biological functioning.[6] Importantly, however, we must not lose sight of the fact that these changes are brought about by psychosocial processes and health behaviours (acting independently and inter-dependently), and that

TABLE 1

AGE STANDARDISED MORTALITY RATES (PER 100,000), RATE RATIOS, AND EXCESS MORTALITY, BY AREA SOCIOECONOMIC STATUS (SES): MALES, 25–64 YEARS, 1985–87, 1995–97 [a]

	1985–1987 Age standardised rate [b]				1995–1997 Age standardised rate			
	High SES	Low SES	Rate Ratio [c]	Excess mortality [d]	High SES	Low SES	Rate Ratio	Excess mortality
All causes	338.4	568.5	1.68	24	250.4	410.8	1.64	26
Circulatory system	125.7	207.8	1.65	24	63.2	118.2	1.87[e]	32
Coronary heart disease	96.0	149.0	1.55	21	43.0	80.7	1.88[e]	33
Stroke	13.1	27.5	2.10	34	7.7	16.0	2.07	36
Diabetes mellitus	4.2	7.3	1.73	24	4.3	9.0	2.07[e]	32
Cancer	117.9	150.6	1.28	12	90.3	125.4	1.39[e]	19
Lung cancer	29.7	47.3	1.60	23	17.6	34.8	1.98[e]	35
Injury and Poisoning	50.6	99.2	1.96	30	43.7	76.9	1.76	30
Suicide	19.5	33.7	1.73	24	22.2	33.8	1.52	23
Motor vehicle accidents	16.8	28.9	1.73	27	8.4	19.6	2.33[e]	41
Respiratory system	13.7	31.7	2.31	37	8.0	20.0	2.49[e]	43
Chronic lung disease	5.1	9.7	1.90	33	4.4	13.3	3.02[e]	53
Digestive system	10.3	31.4	3.06	48	8.8	19.3	2.20	37

a. Source: Adapted from Turrell and Mathers. [5]
b. High and low correspond to the least and most disadvantaged quintiles of the Index of Socioeconomic Disadvantage respectively.
c. Ratio between the standardised mortality rate for the most and least disadvantaged quintile.
d. Per cent of deaths that would be avoided if all quintiles had the same mortality rate as the least disadvantaged quintile.
e. Statistically significant increases in mortality inequality between 1985–87 and 1995–97.

TABLE 2

SOCIOECONOMIC DETERMINANTS OF HEALTH [A,B]

Upstream (macro)	Midstream (intermediate)	Downstream (micro)
Social, physical, economic, and environmental factors	**Psychosocial factors**	**Physiological systems**
• Education	• Control	• Endocrine
• Employment	• Stress	• Immune
• Occupation	• Depression	
• Working conditions	• Self esteem	
• Income	• Social support & networks	**Biological reactions**
• Housing	• Hopelessness	• Hypertension
• Area of residence	• Demand–strain	• Fibrin production
	• Isolation and marginalisation	• Adrenalin
		• Blood lipid levels
	Health Behaviours	• Body mass index
	• Food and Nutrition	
	• Smoking	
	• Physical activity	
	• Alcohol	
	• Self harm	
	• Preventive health care use	
	Main direction of influence →	

a. Adapted from Turrell and Mathers. [4]

b. The table is not exhaustive in terms of its identification of the socioeconomic determinants of health.

these in turn are a consequence of differential exposure to adverse social, physical, economic, and environmental circumstances: this latter group of upstream factors is where the 'problem' of socioeconomic health inequalities originates.

An important first issue for policy is at what stage in the disease process do we intervene. It is implied in Table 2 that policy and intervention efforts can be directed at upstream, midstream, or downstream influences. However, where we focus and concentrate our efforts has implications in terms of making a measurable impact on health inequalities. Attempts to tackle health inequalities by focusing on upstream factors are likely to result in the greatest impact on population-wide differentials. However, societal-level changes are the most difficult to bring about, and the most politically sensitive. By contrast, policies and interventions that focus on midstream factors might benefit the groups or areas that are targeted, but they are unlikely to reduce inequalities at the national level. In other words, midstream efforts might improve psychosocial health, or result in behaviour change, but they are not likely to alter the social and economic conditions that gave rise to the problems in the first place. We could also focus our efforts at the micro level via, for example, health promotion information provided at visits to general practitioners. This approach, however, while important, probably only serves to improve individual health, and it is not likely to impact in any discernible way on national-level health inequalities.

Second, while approaches will differ in their impact depending on where they are directed (upstream, midstream, or downstream), attempts to tackle health inequalities should focus simultaneously on all three levels of influence. Policies and interventions need to be implemented on a broad front.[7]

Third, evidence about the causes of socioeconomic health inequalities points to the need for a 'whole of society' approach to the problem. Health inequalities originate from societal-level conditions associated with housing, employment, education, income, transport, etc; and reducing inequalities will not be achieved exclusively (or even primarily) by actions taken within the health sector. An effective response to the poorer health of disadvantaged groups will therefore require actions from all public sectors, and thus inter-sectoral collaboration and joined-up efforts are essential. In this respect, workers in the health sector can play an important advocacy role by ensuring that public policy makers are informed about the possible consequences of their decisions and actions for the health of disadvantaged groups.

Fourth, sociologists have long argued that social, economic, physical, and environmental contexts exert an independent influence on health, separate from the characteristics of individuals within these contexts. Recent studies using multi-level research designs and statistical methods have provided empirical support for these claims.[8] In terms of policies and interventions, this evidence suggests that efforts to tackle health inequalities should focus on both contexts and individuals by taking

a social–ecological approach to the problem.[9] To date, policy and intervention efforts have largely been non-contextual, and targeted at individuals, which has had limited success in terms of reducing socioeconomic health inequalities. Indeed, an individualised approach may have actually widened health differences between social groups.[10] For example, health promotion programs that attempt to change individual behaviour have been more effective among the socioeconomically advantaged.[11] This is because disadvantaged groups are often constrained by their social and economic circumstances in ways that make behavioural change difficult.

Fifth, while national public (health) policy and interventions have apparently been effective in terms of improving average health, population-wide approaches do not necessarily alter underlying health inequalities. This is clearly evident in Table 1, which shows that socioeconomic health inequalities remained unchanged (or increased) between 1985 and 1997 even though everyone's overall health improved. This suggests that national efforts to improve health need to be complemented by policies and interventions that are designed with, and for, socioeconomically disadvantaged groups.

Sixth, attempts to understand the genesis of socioeconomic health inequalities have increasingly focused on the influence of factors that occur at early or critical stages of development (in utero, infancy, childhood),[12] and across the lifecourse.[13] Studies examining these issues have shown that propensity for poorer health in adulthood is greatest among those from disadvantaged backgrounds in childhood (irrespective of what happens in the intervening years between childhood and adulthood). Moreover, it is now clear that disease risk accumulates longitudinally over the lifecourse, such that the worst health is experienced by those who have the greatest cumulative exposure to social and economic adversity. Taken together, this evidence suggests that early life, and mothers and young children in particular, should form an important focus of our policy and intervention efforts to reduce socioeconomic health inequalities. Focusing on this lifecourse stage and social group is likely to result in health benefits for current and future generations.

Finally, the Australian health care system plays a crucial role in terms of moderating and hence minimising health inequalities. Integral to this is the maintenance of a universal, non-targeted system that is economically, geographically, and culturally accessible. Importantly, the health care system is more than simply a biomedical curative entity: it also encompasses primary and community care, including home care, community health centres, disease prevention and health promotion, and the public health sector. Those who preside over the distribution of health care funds might want to consider evidence from overseas studies which suggest that the greatest potential impact of the health care system in terms of minimising health inequalities is via a more equal distribution of funding and resources between these non-clinical preventive components and the more clinically oriented curative component.[14,15]

In summary, reducing socioeconomic health inequalities represents a major policy challenge. Health inequalities need to gain greater public visibility, for public opinion and support are likely to be important 'push' factors in any government's decision to address the problem. Public policy and health policy need to work in concert, to inform one another, and be directed at countering the life circumstances that generate poor health, and promoting those that give rise to good health.

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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 [*NSW Public Health Bulletin* 2001; 12(7): 183–185], 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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HEALTH, WELLBEING, AND PROGRESS

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Is it enough to say that, because we are growing richer and living longer, life is getting better? Wealth and health are the main indicators by which we judge progress, and by these measures Australia, and most of the rest of the world, are making good progress. So is all well and good? Not exactly. There is growing evidence that standard of living is not the same as quality of life, and that how well we live is not just a matter of how long we live, especially in rich nations such as Australia. This article describes the relationship between health, wellbeing, and progress.

The increasing interest in how we define and measure 'progress' has paralleled the resurgence of interest in the social determinants of health. Just as the literature on social determinants provides a larger context to the focus on 'individual risk factor' of much health research—and so improves our understanding of the causes and correlates of disease—so research related to measuring progress can enlarge our understanding of social determinants of health and wellbeing. This research spans several disciplines, including developmental studies, economics, environmental science, sociology, and psychology.

From a political perspective, progress is about chasing economic growth. It is striking just how much the political framework of growth is regarded as a 'policy constant' that is beyond scrutiny or debate. Political leaders explicitly state high growth as their prime objective, believing it to be the foundation on which social progress, including better health, is built (the Prime Minister, John Howard, once said that his Government's 'overriding aim' was to deliver growth of over four per cent per year).[1]

What does the literature on social determinants reveal about this priority? Life expectancy rises with per capita income at lower income levels, but among rich nations, it is at best only weakly related to average income.[2] In these countries, health may be more strongly associated with income distribution, with more equal societies enjoying better health. However, this population-level association between inequality and health is contested.[3,4] At the individual level, the findings are unequivocal: health inequalities exist in all societies. On average, people at any point on the socioeconomic scale enjoy better health than those below them, but poorer health than those above. Overall, the research suggests that increasing equality in Australia would do more for population health than increasing average income.

Doubts about the nexus between growth and progress have spurred the development of indices, such as the Index of Sustainable Economic Welfare and the related Genuine Progress Indicator, that attempt to correct some of the anomalies and omissions of Gross Domestic Product or GDP, by which we measure growth.[5] The new indices adjust GDP for a wide range of social and economic and environmental factors, including income distribution; unpaid housework and voluntary work; loss of natural resources; and the costs of unemployment, crime and pollution. These 'GDP analogues' show that trends in GDP and social wellbeing, once moving together, are diverging in most, if not all, Western countries for which they have been constructed, including the United States, United Kingdom, and Australia.[5,6]

The new indicators support a threshold hypothesis proposed by the Chilean economist Manfred Max-Neef.[6] In the late 1980s, he and his colleagues undertook a study of 19 countries, both rich and poor, to assess the things that inhibited people from improving their wellbeing. They detected among people in rich countries a growing feeling that they were part of a deteriorating system that affected them at both the personal and collective level. This led the researchers to propose a threshold hypothesis, which states that for every society there seems to be a period in which economic growth (as conventionally measured) brings about an improvement in quality of life, but only up to a point—the threshold point—beyond which, if there is more economic growth, quality of life may begin to deteriorate.

International comparisons show a close correlation between per capita income and many indicators of quality of life, but the relationship is often non-linear: as with life expectancy, increasing per capita income confers large benefits at low income levels, but little if any benefit at high income levels. This is especially so with subjective indicators such as happiness and life satisfaction. Further, the causal relationship between wealth and quality of life is often surprisingly unclear. While surveys show most people are happy and satisfied with their lives, personal life satisfaction and happiness have not increased in Australia and other rich nations in recent decades (50 years in the United States) despite increasing average per capita income.[7]

People are more negative about social conditions and trends than they are about their own lives.[8,9] Polls over the past four years have shown that, at best, less than one-third of Australians believe overall quality of life in Australia is getting better; as many as a half think it is getting worse. The research indicates many people are concerned about the greed, excess, and materialism that they believe drive society today, underlie many social ills, and threaten their children's future. They want a better

balance in their lives, believing that when it comes to things like individual freedom and material abundance, people do not seem to 'know where to stop' or now have 'too much of a good thing'. In one study, the most common reasons given for perceptions of declining quality of life were: too much greed and consumerism; the breakdown in community and social life; and too much pressure on families—factors linked to economic growth processes.[10]

The research on progress highlights the need to question the assumptions about growth that inform our politics. The first is that wealth creation comes first because it allows us to spend more on meeting social and environmental objectives. This is understandable: higher growth, more revenue, bigger budget surpluses, more to spend on new or bigger programs. However, if the processes by which we pursue growth do more damage to the social fabric and the state of the environment than we can repair with the extra wealth, then we are still going backwards. 'Efficiency' in generating wealth may well mean 'inefficiency' in improving overall quality of life.

A second, related assumption is that increased income is better, 'all other things being equal', because it increases our choices, our 'command over goods and services'. Again, this view seems straightforward and compelling. But other things rarely if ever remain equal because the processes of growth tend inevitably and inherently to affect 'all other things'. If the pursuit of growth becomes so dominant that it crowds out or undermines the personal, social, and spiritual ties that underpin health and happiness, then 'more' is not better but worse.

What emerges from this broader view of progress—and what the literature on health inequalities pays scant attention to—is the importance of culture to health and wellbeing.[11] Culture refers to the webs of meanings, beliefs, and values that define how we see the world and our place in it, and so what we do in the world. Healthy cultures bind societies together; they allow us to make sense of our lives and sustain us through the trouble and strife of mortal existence.

Our focus on economic growth reflects defining cultural characteristics that include consumerism, individualism, and economism (regarding human societies primarily as economic systems in which economic considerations govern choice). There is growing evidence that these cultural factors can directly affect health and wellbeing. The complexities of the associations between sociocultural factors and health can be illustrated by looking at psychosocial problems in young people, particularly youth suicide, which have increased in most developed nations in the past 50 years.

There is a clear socioeconomic gradient in suicide among young men (aged 15–24) in Australia—that is, rates decline with rising socioeconomic status—and the gradient increased (became steeper) between 1985–87 and 1995–97.[12] With death related to drug-dependence, however, the gradient apparent in the mid-1980s had almost disappeared a decade later—that is, there was little difference between groups. Among young women, the gradients for both suicide and drug deaths are reversed over this period—that is, deaths in the mid-1990s are higher in the high socioeconomic group than in the low. For all causes of death, the socioeconomic gradient increased for young males, but declined for young females. Clearly, factors other than socioeconomic status affect health.

In a cross-country analysis, a colleague and I found strong positive correlations between several different measures of individualism and youth suicide, especially for males.[13] In contrast, socioeconomic factors—such as youth unemployment, child poverty, income inequality, and divorce—did not show significant correlations, which is not to say that these factors do not play a role. Individualism places the individual, rather than the community or group, at the centre of a framework of values, norms, and beliefs; and emphasises personal autonomy, independence, and 'self-actualisation'. Most of the measures of individualism used in our analysis were based on survey questions—for example, asking how much freedom of choice and control over their lives young people felt they had.[13]

While individualism might affect health and wellbeing through specific effects on families and parenting, for example, it could also exert a more pervasive influence, contributing to a lack of appropriate sites or sources of social identity and attachment; and, conversely, a tendency to promote unrealistic or inappropriate expectations of individual freedom and autonomy. And individualism, when taken too far, may be more harmful to men than to women because men and women construe the self differently—men as independent, women as interdependent.[14]

CONCLUSION

Several observations flow from a broad perspective on progress, health, and wellbeing: our health is influenced by the most fundamental characteristics and features of our societies; these qualities are cultural as well as material and structural, a question of subjective perceptions as well as objective realities; and the complexities and subtleties of the interactions between these factors make a mockery of our crude equation of growth with progress.

Further, a strategy that is beneficial at one stage of social development is not necessarily appropriate at another. Standard of living, measured as rising income, may once have been a useful, easily measured proxy for quality of life and wellbeing, and it may remain so today for developing countries. But in Australia and other rich countries, the pursuit of ever-greater wealth may now be

becoming a health hazard. We need to pay attention to the content of growth—and the values and priorities it reflects and serves—not just to its rate.

We ought to think less in terms of a 'wealth producing economy' and more about a 'health producing society', where health is defined as total wellbeing: physical, mental, social, and spiritual.

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