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UNDERSTANDING HEALTH: AN INTRODUCTION

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OVERVIEW

Health is the most fundamental, yet complex, condition of life. Without good health, wellbeing, and life itself, are compromised. As we navigate a world where major threats to health come from old and new diseases, from climate change and the need for environmental and social responsibility, our health workforce is seeking to understand these issues and what they can do to address them, particularly through public health approaches. While the COVID-19 pandemic has brought into stark relief the importance of the health of populations and of public health, climate change and the health of the planet are ongoing challenges. In this chapter we start our journey by exploring the different meanings of health, and introduce both public health and the concepts of health equity, fairness and justice.

KEY QUESTIONS

1 What are the different ways that health can be understood and explained?
2 How are theories and models that explain health used by different professions?
3 What is health equity and what does it have to do with social justice?
4 What is public health?

KEY CONCEPTS

- Models of health
- Theories of health
- Health status of individuals and populations
- Public health
- Health equity and inequity
- Social justice

Introduction

health
A resource for living that permits people to lead a meaningful life.

This book is for professionals of all types whose roles and responsibilities are connected with **health**. In particular, it is for those who are working to maintain or improve the health of communities and populations—and the health of environments around us, because we are only as healthy as the world in which we live. Through this book, we aim to assist you to develop interdisciplinary or cross-disciplinary capabilities, starting with understanding the perspectives of different disciplines and how they think about health. This understanding is critical for all health professionals because it helps them work collaboratively and problem solve.

Good health is a desirable and valued social goal for people because health is essential for life. In Australia, we have high expectations that everyone will experience good health. However, those expectations are challenged by new patterns of disruption and poor health arising from disease and environmental disasters including bushfires, floods and droughts, alongside the destruction of the natural environment and wildlife and massive shocks to communities from which it can take decades to recover.

This book will lead you into journeys that will enable you to understand health, how it is created, and what we can do as a society to sustain and improve people's health and wellbeing. The core concept of **health status** will be explained through the measures we use to establish variations in health between different groups and populations. Public health is particularly concerned with the health of the most vulnerable people in our society and what is being done to ensure they have **health equity**, which is also a core concept.

health status
A relative level of wellness, taking account of functioning, physical illness and mental wellbeing.

health equity
The rights of people to have equitable access to services on the basis of need, and the resources, capacities and power they need to act upon the circumstances of their lives that determine their health.

When faced with complex problems to solve, professionals use theories, models and knowledge to guide action. In turn, community members and consumers are informed by professionals, although a range of lay theories also become popular to explain issues that people find hard to understand. For example, during the COVID-19 pandemic, some very strange theories about the virus emerged, and there were suddenly more armchair epidemiologists than qualified ones! Many of those lay theories were dangerous, flying in the face of science, reflecting an anti-science movement that has grown almost out of control in the last decade. Experts of the future need to learn how to counter arguments that do not reflect scientific evidence, using public health communication skills and evidence-informed knowledge.

In this first chapter, we introduce models or theories of health and core concepts about health, health care, **primary health care** and **public health,** all of which will be examined in more depth in later chapters of this book. You will learn how theories explain the complexities of health and how health professionals use them to influence change and to improve health for individuals, and for populations.

When you search for theories, for example when reviewing literature to establish new programs, you will also find literature about models and frameworks. What is the difference between them? Here is a quick guide:

- In a theory, you would expect to see a predictive relationship between variables.
- Models tend to be more descriptive but do include concepts as well as steps or phases about how the model works.
- Frameworks also include concepts and categories but do not predict the relationship between variables.

primary health care
Services based on the social model of health and principles of equity, acceptability, cultural competence, affordability, and universalism. Primary health care is essential health care that a country and community can afford with methods that are practical, scientifically sound and socially acceptable.

public health
The field of efforts that maintain life among all our communities, societies and cultures.

Models of health

Models of health are ways of thinking about how health is supported and how health issues are addressed. You will find it useful to have a basic grasp of the most common models of health. These are:

- **Medical model of health:** The medical model of health is based on studies of health and disease in terms of pathology for the detection and diagnosis of illness. The medical model of health is studied in depth by the medical profession and it underpins the studies of nurses, physiotherapists, paramedics, exercise physiologists and many other professions.
- **Biomedical model of health:** A way of thinking about health that focuses on how disease occurs and how it can be prevented, and therefore on risk behaviours and healthy lifestyles. It emphasises health education to change knowledge, attitudes and skills (VicHealth n.d.). Biomedicine includes studies in haematology, immunology, biochemistry, bioinformatics and human genetics.
- **Behavioural model of health:** The behavioural/lifestyle or psychological perspective focuses on how to change risk factors

medical model of health
A way of thinking about health that is based on the detection and diagnosis of illness. It focuses on pathology.

biomedical model of health
A way of thinking about health that focuses on how disease occurs and how it can be prevented, and therefore on risk behaviours and healthy lifestyles. It emphasises health education to change knowledge, attitudes and skills (VicHealth n.d.).

behavioural model of health
A way of thinking about health that focuses on how to change risk factors among individuals and at population levels, to influence lifestyle behaviours.

among individuals and at population levels, to influence lifestyle behaviours. Lifestyle approaches are widely used by behavioural and medical professionals and studied in depth by psychologists.

- *Public health:* Public health is the field of efforts that maintain life among all our communities, societies and cultures. Public health measures have been taken by civilisations for centuries, but of course in the twenty-first century we are able to draw on solid evidence about what works to maintain health and life among all of us. Public health is studied by epidemiologists, public health and health science professionals as well as many clinicians at postgraduate level who wish to learn more about how to prevent disease and illness in populations. Public health is based on values of fairness, equity and **social justice**.
- **Social model of health:** The social model of health examines the social, cultural, political and ecological factors that contribute to the health of individuals and populations. This model of health was influential in the development of concepts now broadly called the determinants of health. Many professions study the social model of health but those that study it in-depth include social work, occupational therapy and health promotion.
- **Community development model of health:** Communities know when their health is being affected by stressors such as inappropriate industrial development or poor traffic planning. The community development model is based on principles that communities can and should be actively involved in identifying, planning, designing and implementing solutions to health issues and strategies to reduce health inequalities.

social justice
An ethical concept based on upholding human rights and redressing equity and inequity and unfairness in society in terms of wealth, opportunities and privilege.

social model of health
A way of thinking about health in terms of the social, cultural, political and ecological factors that contribute to the health of individuals and populations.

community development model of health
A way of thinking about health based on the principle that communities can and should be actively involved in identifying, planning, designing and implementing solutions to health issues and strategies to reduce health inequalities.

In addition to these models of health, there are a range of *cultural models,* which reflect the varying interpretations of health and how to maintain it that people from different cultures and professions have. It helps to have some understanding of these models because you will work with diverse people and communities during your career.

These models have strong scientific and evidence-based foundations. Nevertheless, you will also see that many people and organisations hold ideas about health that are determined more by values and beliefs than by scientific evidence. As a professional who will contribute to health, you will benefit from understanding the theories underpinning these models so you have a well-rounded understanding of how health is created, how people cope with illness and how different professions work to maintain health and wellbeing. The next section provides a snapshot to get you started.

Pause for reflection

Which model of health do you think you will find useful in your studies and future career? What is another model you think you should learn more about?

What is a theory of health?

The function of a theory is to explain the complexity of the world and predict what might happen if one or more important factors or variables change. Climate change theory is a good example. Over time, scientists are consistently predicting what will happen to our planet as it becomes warmer and how that will affect people's health. In other words, scientists are searching for the evidence to explain or predict relationships between variables.

Theories are often conceptual—they work at a high level, rather than at a content level or issue-specific level. Theories about health may reflect similar general ideas about how to improve health and prevent disease, but they vary in the way their concepts are framed and developed. For example, a public health theory will be developed on the basis of populations, whereas a medical theory is more likely to be about a condition that affects individuals. Often, these theory types are combined.

There are two major groups of theories about how health problems develop: structural theories and agency theories. A structural theorist argues that particular groups of people get sick more than others primarily because of the structures, policies and politics that determine how a society is organised. They see that societies can be organised in ways that are more or less likely to improve the health of all people, including those who are disadvantaged.

By contrast, agency theorists locate the causes of illness in the health behaviours and lifestyle choices of particular individuals and groups. They promote lifestyle and behaviour change theories.

However, while such theories have their place, they don't work in the absence of structural theories. For example, efforts to change people's behaviours during the COVID-19 pandemic, or to change norms and attitudes about violence against women have the right intent, but they only work when there are higher level levers that governments can pull to ensure that change is sufficiently embedded at a structural level to affect people's thinking and actions.

These fundamentally different explanations of the development of disease—structure versus agency—lead to very different ideas about how to address health issues. These different theories will be revisited throughout the book.

In summary, a theory is a set of assumptions, or propositions and **hypotheses** that are assembled to provide a plausible or rational explanation of the cause-and-effect of observed occurrences or experiences in the world. Some theories are established, while others are emerging, but all theories are subject to new knowledge and learning and may be challenged by new evidence. To become an accepted theory, assumptions, hypotheses and propositions have been tested repeatedly through research, to strengthen the validity of the theory.

hypothesis
A supposition or proposed explanation made on the basis of limited evidence, which is then used as a starting point for further research or investigation.

Pause for reflection

A hypothesis is a supposition or proposed explanation that is made on the basis of limited evidence. It is then used as a starting point for further research or investigation. A simple hypothesis predicts the relationship between two variables: the independent variable and the dependent variable. Can you think of an example of a simple hypothesis? Think about two variables—for example, (1) the predicted health outcomes (2) when people consume sugary drinks.

Of course, the models of health and the theories behind them don't stand alone—there is interaction between them in both research and health practice as professionals work together to advance health and prevent illness.

Professions' views of health

Many health professions learn what we call 'natural science' theories, which are based on the science and practice of the diagnosis, treatment and prevention of illness and disease. Some of these professions are regarded as clinical, such as doctors and nurses, while others are regarded as non-clinical. The non-clinical professions include public health and health promotion, although many public health professionals have also studied medicine, nursing or an allied health course. Many clinicians take up postgraduate studies in public health to broaden their understanding of health beyond the care of individuals and to help influence policy for effective health systems that respond to populations' health needs.

Some clinical professions, including nursing and the allied health professions, are educated in modalities designed to treat disease or prevent its recurrence as well as the social model of health. The focus of many clinical professions is largely individualised care, so their views of health are predominantly about the health and wellbeing of individuals. Their work is mostly, but not entirely, based on their observation of diagnosable symptoms, which is why they are called clinicians.

Midwifery is entirely about the care of women during pregnancy, labour and the postpartum period, as well as care of the newborn. Their studies are grounded in learning about the social, emotional, cultural, spiritual, psychological and physical experiences of women.

While some public health work is with individuals, public health primarily draws on structural and political paradigms to learn more about the health of populations and how to improve it. Public health professionals are concerned with activities that aim to enhance the conditions or environments that are healthy for people, so their focus is on entire populations rather than on individual patients or diseases.

Studies of health and illness utilise the expertise of social science, political science and natural sciences, which expand our understandings about patterns of health and illness in populations. This knowledge assumes that health and illness cannot be explained or influenced by professionals from the health sector alone. Contemporary public health emphasises and embraces the role of many sectors beyond the health sector, because they are major contributors to the environments and structures that support and create health. Public health, then, is not just about the health sector, but also those sectors that support the health and wellbeing of individuals, groups and populations by contributing to people's daily lives. For example, many local governments have Public Health and Wellbeing Plans that guide the provision of services and programs in areas such as environmental health, gender equity, the management of waste and rubbish, the maintenance of green spaces, and safe cities and towns. Housing and education are sectors that also have a direct influence on people's capacity to live in good health.

Considering the above, clinicians seeking to influence the delivery of health care, or public health professionals working to develop good public health planning, all need to have a solid understanding of how health is created, how it is diminished and what to do about it within their scope of practice. When working with individuals, professionals always need to take account of a person's own perspectives and their capacity to manage or control the challenges in their lives.

You will find that approaches to how different professionals and citizens understand health are influenced by systems of beliefs and values about health and that some beliefs and values are given precedence over others. How we act is shaped by whether

our focus is on lifestyles, the social model of health, public health/health promotion, or any combination of these.

We also know that knowledge is not linear and cannot be contained within silos. Models of health recognise a variety of causal pathways to good health, poor health or disease in a population. Although models of health overlap, most health professionals' practice draws predominantly from one or two of those models.

What is public health?

Public health is defined as those organised measures that are taken to protect health among populations, to prevent disease, promote health and prolong life among the population as a whole.

Public health is a value-driven system based on social justice and equity, and also on the 'Health for All' movement started by the World Health Organization (WHO). However, it is also driven by high-level evidence about what works. Crucially, there are powerful economic drivers for public health. For example, populations that enjoy good health contribute to a more productive economy because there is a healthy workforce. Health economics has shown that we minimise the impact of illness and the costs of treatment by maintaining good health among the population.

determinant
A foundational or underlying cause of a problem or health issue. Determinants include the social, political, economic and cultural conditions in which people live. They are understood as the factors that determine or decide the likelihood of an outcome occurring.

Public health is a system for the prevention of illness, disease and poor health. Health protection, health promotion and prevention are the three key pillars for a strong public health system and provide a framework for practice. Going more deeply, the principles for improving the public's health are based on the **determinants** of health and illness in the population, health equity, social justice, ethics and cross-sector collaboration as well as community consultation.

To meet these demands for high-quality public health to protect people from the hazards all around them, we require a multidisciplinary workforce, educated and trained to the highest standards of public health. People, at least in Australia, expect that governments will protect their health from obvious threats or hazards. We call this work 'health protection', and most governments undertake it, more or less. We expect governments to place a high value on public health as one of their fundamental roles, but not every government has invested in public health to the level needed. This rapidly became obvious as COVID-19 spread around the globe, as Case study 1.1 illustrates.

CASE STUDY 1.1

THE UNFOLDING OF A PANDEMIC DISASTER

On 31 December 2019, a pneumonia of unknown cause detected in Wuhan, China was first reported to the WHO Country Office in China.

On 20 January 2020, the WHO made its first situation report on COVID-19, and ten days later it declared COVID-19 an international emergency. The WHO had published a report in 2017 on how to implement biosecurity measures in a pandemic and countries were urged to implement those measures immediately. Some countries were quick to respond; others were much slower.

On 27 February 2020, Australia declared that COVID-19 would become a global pandemic and extended its travel ban on visitors from China, as a surge of new cases around the world fuelled fears containment measures had already failed. On 18 March 2020, in response to emerging COVID-19 outbreaks in Australia, the Governor-General declared a human biosecurity emergency. The declaration gave the Minister for Health expansive powers to issue directions and set in train the requirements necessary to combat the outbreak. This was the first time these powers under the *Biosecurity Act 2015* (Cth) had been used (Maclean & Ephick 2020).

Australia was relatively fast to react to COVID-19. By 20 March 2020, it had closed its borders to international travel and enforced strict quarantine regulations for people arriving in Australia or exposed within Australia. There were some breaches, including through a cruise ship and hotel quarantine programs, which gave rise to early spread of the virus. Testing criteria in the first few weeks of the pandemic were quite tight due to the shortage of kits and capacity for testing, but as capacity increased, testing regimes were broadened.

The first confirmed cases of COVID-19 outside China were around 20 January 2020. The first deaths in the USA and South Korea occurred in late February. By April, there were 800 deaths a day in the USA. By mid-May, Australia had recorded 98 deaths in total and fewer than 7,000 infections. Australia and South Korea had begun following very different paths to the USA, with very different outcomes.

Australia, New Zealand, South Korea, Singapore and a few other countries embarked on containment of the virus. They implemented widespread testing, tracking of cases, quarantining and hygiene measures, including the wearing of masks. While there were spikes of new cases in every country over 2020, these countries managed to contain the spread.

The US response was very different, primarily because the resistance to public health measures was politicised and people refused to even believe that the virus was real, let alone practise the hygiene measures that other countries mandated. As a result, throughout 2020, cases and death rates continually grew across the USA. By early April, about 2,000 Americans were dying each day, with the USA having the highest death toll of any country. By August, its death toll was over 150,000 and by the time the first vaccine was given on 14 December 2020, more than 300,000 Americans had died. This was out of a global death toll to that point of more than 1.7 million people, though this is only an estimate: the actual toll is likely to be much higher. At the time of writing, over 600,000 Americans have lost their lives.

Pause for reflection

There are excellent up-to-date statistics on COVID-19 at www.worldometers.info/coronavirus. You can review the reported cases by country, including total deaths, deaths per one million people and total tests per one million people.

Read Case study 1.1 and review the current COVID-19 statistics for the countries mentioned in the case study. What do these countries' statistics say about their public health systems and the leadership provided by their governments?

Public health theories and models

The pandemic demonstrates the difference between biomedical and public health theories and models. Biomedical approaches, or the medical model, involve expert health professionals diagnosing and treating people one at a time. COVID-19 caused a range of severe problems, requiring highly trained staff working in multidisciplinary teams, advanced hospital design and expensive medical devices and drugs. The medical model is essential for trying to cure individuals, or at least ensuring they have the most dignified death possible. But in pandemics and daily life alike, the medical model cannot stop the flow of new patients. Public health saved millions of lives during the pandemic because public health takes a whole-of-population perspective. During the pandemic, public health professionals worked to find the origins and architecture

of the virus and then worked out how it spreads in order to stop it spreading. The most effective responses to COVID-19 seemed to be in countries with well-funded, universal health care systems in which biomedical and public health perspectives were brought together—and these were not always developed countries with high per capita incomes.

Epidemiologists, sometimes called disease detectives, are central to the public health workforce. They used sophisticated methods to chart the patterns and spread of COVID-19, which informed the measures taken by governments to control the spread of the virus. One of the first actions taken was to close national and international borders when it became apparent how quickly the virus was spreading via travellers. Another action was to rapidly expand contact tracing, which involves contacting everyone who has been close to an infected person, so they can be tested and monitored. Governments were under enormous pressure to manage the politics of border control, lockdowns, contact tracing and epidemiological modelling.

In addition, approaches to change people's behaviours involved marketing, advertising and campaigns to encourage people to wear masks, wash their hands, contain sneezing, maintain physical distancing and refrain from physical contact with others such as hugging and handshaking. Other approaches included border restrictions and widespread testing, which were considered to be an 'aggressive public health response'. In Australia, that response is thought to have saved thousands of lives (Macauley 2020).

Public health is about saving lives, albeit at the cost of some initial economic and personal hardship. During the first phase of the pandemic governments in Australia met with, listened to and delivered daily press briefings with senior medical and public health officers. They reassured the public that the stringent measures taken to contain the spread of the virus carried the weight of science and were medically responsible. Public health communication is vital to explain pandemics, the broader determinants of health and the economic and social impact of poor population health. There were high profile interest groups and political leaders spruiking anti-science and conspiracy theories. We heard racist and xenophobic explanations for COVID-19, while dangerous miracle cures were touted.

As the public health disease detectives did their work, attention soon turned to an **ecological model of public health**—interrogating the extent to which past epidemics, this pandemic and future disease patterns resulted from changed relationships between humans, animals and environment during climate change and industrialisation.

ecological model of public health
A way of thinking about health in terms of the complex interrelationships and interdependencies between human beings, the determinants of health and the broader environment in which they exist.

As the pandemic continued during 2020, it became apparent that it did not affect population groups in the same way. People already living with disadvantages were hit harder, both by the virus and

health inequities 'The unfair and avoidable differences in health status seen within and between countries' (WHO n.d.b).

the stringent measures to combat it, which caused millions of jobs to disappear. The pandemic shows how **health inequities** arise from economic, cultural and social conditions and the way that a society's resources are distributed.

Health equity and inequity

Health inequities are differences in health status that are unfair because they can be prevented. As shown in Case study 1.2, in Australia, Aboriginal and Torres Strait Islander peoples experience higher disease rates and more premature deaths due to economic, cultural and social conditions and the way that society's resources are distributed. This includes, for example, access to money, health and social services and quality educational opportunities. Another way to think about health is to see in what ways health plays an essential role in human life and gives people the freedom to do the things they wish to do (Sen 2004). These are issues of social justice and human rights.

Not everyone has the same level of freedom to pursue their aspirations because where someone lives, and the emotional and economic support they have around them to pursue their ambitions, are not available to everyone in the same measure. When we talk about health equity or social equity we open a conversation about issues of fairness and justice. That is, about the way a society arranges the social conditions of living and how those conditions create health or illness.

The terms equity and equality are sometimes used interchangeably but there are important distinctions between them:

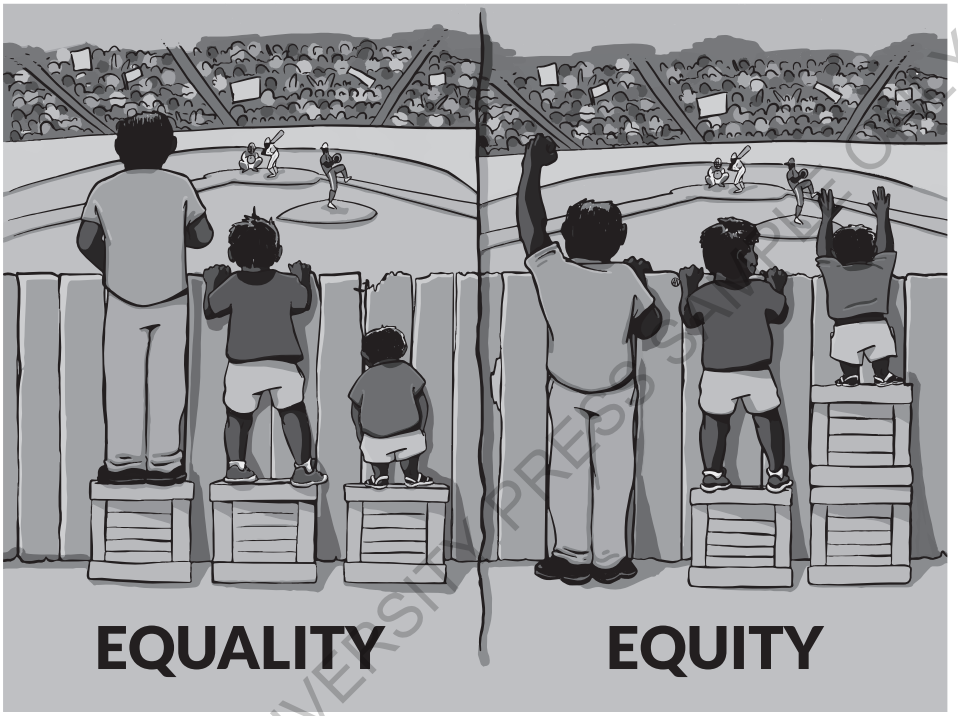
- Equity involves trying to understand and give people the resources they need to enjoy a healthy life. Equity requires the more or less equal distribution of goods and services usually on the basis of need.
- Equality aims to ensure that everyone gets the same things in order to enjoy a healthy life. People who advocate for equality can still believe in fairness and justice, but the pursuit of equality can only work if everyone starts from the same place and needs the same things.

Inequality and equality are dimensional concepts, meaning they are terms that refer to quantities or distributions that are measurable. Therefore, health inequality is a term used to designate the (measurable) differences and variations in the health achievements of individuals and groups, whatever the cause.

Inequity and equity are relational concepts, with political and social justice dimensions. Inequity and equity involve relations of equal and unequal power (political, social and economic) as well as justice and injustice. Inequities need public policy-driven solutions.

It is important for all health professionals to understand the differences between the concepts of inequality and inequity, because they will see how each of these results in differences in health outcomes between groups of people.

Figure 1.1 The difference between equity and equality



Source: Interaction Institute for Social Change n.d.

Pause for reflection

When you look at Figure 1.1, what do you see?

In your own words, describe the difference between equity and equality. Thinking about your own life, were there times when you realised that not everybody has the same advantages as you?

What things make a difference to achieving equitable social and health outcomes for people?

Health inequities are inequalities in health that are unfair or stem from injustice. For example, people in disadvantaged areas experience health inequities because their access to, and the distribution of, services is unfair. In other words, inequity is grounded in social justice, and not just in the availability of health care. Health and social inequities are usually preventable.

Returning to the earlier discussion of theories of health, the agency theory has become a political position which purports that people who live with disadvantage have only themselves to blame for making the wrong lifestyle choices. Therefore, they need to be educated to change their behaviour. By contrast, the structural theory argues that a person's health is strongly influenced by their life experiences and harsh daily living conditions, which are largely beyond their control.

Health systems need to be underpinned by social justice approaches to health if priority is to be placed on achieving health as a resource for life and as a human right. Understanding inequity in theoretical and ethical terms will give you a foundation for thinking about how the health system tackles health inequities and injustices, while also seeking to improve the health of populations overall.

priority population groups
Populations most impacted by significant or priority health issues and who are therefore most likely to be exposed to a condition or are most vulnerable.

Case study 1.2 highlights the health and social inequities experienced by **priority population groups** in Australia; that is, those that are achieving significantly poorer health outcomes compared to the rest of the population. People from population groups seen as a priority for measures to address inequities may be from a particular cultural background or live in geographically underserviced areas of the country that offer limited access to health care and other needed services. Aboriginal and Torres Strait Islander people are considered a priority because, overall, their health status is much poorer than for other Australians and English is a second, third or fourth language for many. The health status of rural and remote Aboriginal people remains the most disadvantaged in Australia.

CASE STUDY 1.2

HEALTH AND SOCIAL INEQUITIES

Australia may be a developed country but the gaps in health and social outcomes have been widening for several decades. One common way to characterise inequities is to see the place of their residence as the

problem. That 'place' may exhibit **indicators** such as low levels of education, income and employment. The social and environmental context of communities can also be critical determinants of people's opportunities to achieve the kinds of life outcomes they wish for themselves and their families.

indicator
A characteristic of a community or population that can be measured, directly or indirectly, and used to describe one or more aspects of the health of that community or population in terms of quality or quantity.

Another common way to characterise clusters of social inequities is through people's identity; for example, Aboriginal and Torres Strait Islander people, people who identify as LGBTIQ+, migrants and refugees, or women. All of those groups experience challenges due to their race, gender identity, sexuality or migration status, and experience discrimination from stereotypes, sexism or disrespect. Their experiences are exacerbated by racism, homophobia, ageism and ableism.

Health and social inequities sometimes occur in areas of urban poverty such as those city suburbs where public housing is concentrated. Locational and socioeconomic disadvantage occur because those areas have poor access to jobs or further education opportunities and, often, poor levels of public transport (that is, they are not on a train line). There are always complex social issues that create **social exclusion** and these in turn can result in concentrations of welfare dependency, sometimes over generations.

social exclusion
The societal conditions in which some people are unable to participate fully in social, political and cultural life, typically because they belong to a minority group or experience poverty.

People living in areas characterised as 'disadvantaged' are much more likely to die prematurely and this gap has widened significantly in recent years. The least advantaged Australians experience higher rates of most types of illness and premature death (Adair & Lopez 2020). These health inequities are underpinned by social disadvantage and social inequities, and are driven by a lack of political will to invest the necessary resources to create the institutional, policy and program responses to redress disadvantage.

All of this shows us that we are only as healthy as the world we live in. The social and structural conditions, natural and built environments, and cultures in which we live all have an impact on our health, as do political influences.

The fundamental moral argument for public health is that if we can save lives and prevent unnecessary death and disease from any cause, then we should. That argument applies to death and disease caused by climate change and other environmental issues as much as it does to the causes of poor health identified by biomedicine. These are fundamental moral arguments about saving lives that are also evident in the way our health system provides treatment for people with cancer or any other condition that threatens life.

Public health uses a wide range of research methods to collect data, which in turn informs efforts to protect and promote health during any outbreaks of illness. Public health has a strong emphasis on increasing health equity and mitigating health inequities that arise from the social and political influences on people's health and wellbeing.

The years 2019 to 2021 will go down in history for the sheer scale of death and disruption they witnessed. First, Australia was hit by massive bushfires during the black summer of 2019–20, and within weeks, the population was confronted by that once-in-a-century pandemic. As noted earlier, globally, millions of lives have been lost to COVID-19. The health of millions more has been compromised. The resulting measures put in place to control the spread of the virus severely restricted people's freedoms and proved personally and financially difficult for millions more people as businesses, schools, universities, the arts, tourism and government services closed, were put on hold or fundamentally changed. Many countries delayed implementing known health protections to limit the effects of COVID-19. So much death and destruction could have been prevented if the right public health measures had been put in place rapidly and without hesitation.

Collaboration across sectors is necessary to deal with the big problems of pandemics, bushfires, climate change and poverty because they are complex problems that cannot be solved by the health sector alone. Only by working across sectors and drawing on the knowledge and skills of a range of disciplines and professions can we even begin to address the causes of disasters or the issues they leave behind.

What is a sector?

Government, industry and community groups are described as working in sectors—the health sector, education sector, welfare sector, agricultural sector or local government sector. The groups within a sector have common characteristics. For example, they might provide similar services or develop related products. Many advances in public health come from working across sectors—for example, a new vaccination service in a country hospital or a campaign that encourages people to learn more about mental

health and talk to others about how to support it. Other advances require cooperation between sectors—for example, joint health and tourism initiatives to make sure there are basic health services in place for busy summer periods, policies that support farmers or 'buy local' campaigns.

Health care systems and primary health care

People from the priority population groups described in Case study 1.2 are over-represented in the health system and in statistics about illness, disease and premature death. Health care is delivered through systems that involve processes of care, policy, financing, a multidisciplinary workforce, treatments and research, to achieve the desired outputs of improved health and quality of life. Significantly, health care systems are shaped by social and political influences and contexts, as Chapter 7 discusses.

Health care systems vary widely around the world, so in this book, we will concentrate on Australia's health system. Models of health care are evident within health care systems. The medical model is perhaps the most prominent, but hospitals, doctors, nurses and allied health professionals cannot operate effectively without an efficient and high-functioning public health system. This became very clear during the COVID-19 pandemic, when public health systems were absolutely critical to the control of the virus. People who were already disadvantaged needed more frequent and intensive treatment in the health care system. In countries where the public health response and functioning was weak or inadequate, many thousands of lives were lost and these deaths could, in theory, have been prevented. In turn, when the public health response to the pandemic was inadequate, health care providers and hospitals were overwhelmed with sick and dying people infected with the virus. The systems set up for health protection were inadequate for a pandemic and were failing.

In turn, primary health care is a sub-system within the bigger health care system, and it became vital to Australia's COVID-19 response. It is an approach to service delivery built on the philosophy of affordable, culturally appropriate, accessible health care services; that is, it is based on both the social model of health and the determinants of health (Chapter 2), and it has the goals of increasing access and advancing equity. It is available from community-based services that strongly identify with local communities and their needs. Primary health care services provide health care at affordable or no cost to eligible people. For example, community health centres provide children's services such as physiotherapy, speech therapy and dental care for a nominal fee for people on low incomes or who hold a health care card. Primary health care systems are discussed further in Chapter 8 and primary health care practice is taken up in Chapter 9.

Summary

Our common purpose in health is to:

- sustain the quality of life of the whole population
- promote equity in health care and public health
- address the inequities that arise from the unequal distribution of power and resources.

To achieve this, we all need to develop not just our knowledge, but also our critical thinking skills. We also need to have a growing understanding of our own competencies and capabilities. Our aim with this book is twofold. First, we want to prepare you for a career that incorporates strategies to improve health, whether you are in the health system or come from one of the many disciplines and sectors whose work is so crucial for health.

Second, throughout this book we look in depth at the evidence and theories that underpin the problems that need to be solved to create healthier populations. We will also ask you to reflect on the skills and competencies in public health that you will need to become an effective and successful professional.

REVIEW YOUR LEARNING

1 How does equity differ from equality and why does it matter?

2 How do values about equity and social justice affect health inequities?

3 Give an example of a priority population group and why those groups are a priority for the health system.

DISCUSSION QUESTIONS

1 What are some different ways in which you, family members, friends and colleagues define health? Given your knowledge of these people, how do you explain these differing views?

2 In the media over the past week, what approaches to health have been dominant? In which media have you found examples of more social and structural approaches to health as opposed to those emphasising agency?

3 Which of the approaches to health in this chapter are new to you or difficult to understand? What learning strategies do you think will help you to deepen your knowledge of these new concepts and theories?

FURTHER READING

Hulse, K., Pawson, H., Reynolds, M. & Herath, S. 2014, *Disadvantaged Places in Urban Australia: Analysing Socio-economic Diversity and Housing Market Performance, AHURI Final Report No. 225*, Australian Housing and Urban Research Institute, Melbourne.

USEFUL WEBSITES

Musolino, C., Baum, F, Womersley, R., van Eyk, H., Freeman, T., Flavel, J., & Earl, C. 2019, *SA: The Heaps Unfair State. Why Have Health Inequities Increased in South Australia and How Can This Trend Be Reversed?*, Southgate Institute for Health, Society and Equity and South Australian Council of Social Service, <https://www.sacoss.org.au/sa-heaps-unfair-state>.

This report charts the growth of inequity in South Australia and proposes explanations for how the relationship between inequity and health outcomes can be changed.

Victorian Health Promotion Foundation 2015, *Fair Foundations: The VicHealth Framework for Health Equity*, VicHealth, Melbourne, <www.vichealth.vic.gov.au/media-and-resources/publications/the-vichealth-framework-for-health-equity>.

The VicHealth framework for health equity is a planning tool for health promotion policy and practice. It outlines the social determinants of health inequities, suggesting how to start making a difference.

World Health Organization (WHO) 2017, *10 Facts on Health Inequities and Their Causes*, <www.who.int/features/factfiles/health_inequities/en>.

This fact file looks at what health inequities are, provides examples and shows their cost to society.