Chapter 1

Concepts of Health

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Key concepts

- Health
- Health equity and inequity
- Theories of health

Chapter objectives

Once you have read and worked through this chapter, you should be able to:

- describe different concepts of individual and population health, explaining the key differences between them
- explain the concepts and theories of health that are most common in health and related professions
- identify key theories that underpin concepts of health
- identify different theories of health used by different professions
- distinguish between inequity and inequality
- understand the social gradient in health.

INTRODUCTION

health
A resource that permits people to lead individually, socially and economically productive lives. It is a positive concept emphasising social and personal resources as well as physical capabilities.

Health is one of the most fundamental conditions of life. Feeling healthy is core to our everyday lives and is reflected in the common greeting, 'How are you?' Rarely does a day go by when we don't consider our own health, and inquire about the health of others.

Of course, people and cultures, groups and societies interpret the concept of the health in different ways. Moreover, in Australia and around the world, we are seeing rising rates of poor health. Australia's National Health Priorities reflect the conditions causing the highest burden—heart disease, cancer, type 2 diabetes, mental health conditions, injury, violence

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biological approach to health
Explores the role of genes and risk markers and their interactions with other determinants of health.

biomedical approach to health
Sees health and illness in terms of an individual's medically defined pathology.

primary health care
Community-based services based on the social model of health, guided by principles of equity, acceptability, cultural competence, affordability, and universalism, and a commitment to community and health development. Primary health care incorporates essential health care made accessible at a cost that a country and community can afford with methods that are practical, scientifically sound and socially acceptable as well as essential services for health including water and sanitation, housing, shelter, freedom from violence, and adequate food.

against women and children, and dementia. In the developing countries of the world, where four-fifths of the world's people live, non-communicable diseases such as depression, heart disease and road traffic deaths are fast replacing infectious diseases and malnutrition as the leading causes of disability and premature death. As a result, there is increasing interest in what can be done to stem the tide of poor health and to better understand the causal pathways to health and illness. A common question asked by health researchers is, 'Why are some people healthy and others not?' Researchers and practitioners who are concerned with poor health also want to make a difference to people's lives and opportunities by improving health.

This book is about the health of communities and populations including the health of environments around us because we are only as healthy as the world in which we live.

As a professional whose work affects health, your work is essential to that vision. This book, *Understanding Health*, 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 improve people's health.

In this chapter we explain some of the different ways that professions and cultures think about health and compare those views to the many different ways in which citizens think about health. In later chapters of the first part of this book you will read about the approaches and practices of primary health care, public health, global health, health promotion and primary prevention, and the determinants of health—those factors that influence health. All these approaches are concerned with the health of the most vulnerable people in our society, and these are also a focus of this book. Once you understand the determinants of health, you will have a powerful foundation for understanding approaches to advance health and well-being for populations.

CONCEPTS OF HEALTH

Health is a dynamic concept with multiple meanings that are dependent on the context in which the term is used and the people who use it. People see health as essential to well-being, but how people define their own health varies according to their own social experience, particularly in relation to their age, personal knowledge, and social and illness experiences.

People put a high value on health because while money and power provide the means for people to attain material things that may benefit their lives, no one can actually buy health. In other words, health itself cannot be bought and sold in the marketplace, although health services can be both bought and sold. Health is intrinsically tied to people's sense of well-being and therefore occupies a higher order of meaning in people's lives (Anand 2007).

The Greek, Democritus, writing in the fifth century BC, said that 'without health nothing is of any use, not money nor anything else'; and the famous philosopher Descartes, some 2000 years later, wrote: 'The preservation of health is … without doubt the first good and the foundation of all the other goods of this life' (cited in Anand 2007, p. 17).

Koos (1954) captures the complex and mysterious nature of health in his statement that 'health is an imponderable'. In other words, the state of health is one of the mysteries of life.

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It is complex and difficult to describe. In keeping with that we choose not to recommend a particular definition of health but instead identify a number of different approaches to understanding health and well-being.

The section below explains how different disciplines have different perspectives in how they understand health. Each perspective affects how those disciplines or practitioners approach their health practices so it is useful to grasp the differences between their approaches:

- The **biological approach**: biology is the study of life and living organisms in cells, tissues and organs, so the biological approach to health explores the role of micro-organisms in disease, as well as the study of genetics and risk markers.
- The **biomedical approach** studies health and illness in terms of people's medically defined pathology.
- The **primary health care approach** seeks to advance equity, access, empowerment, community self-determination and intersectoral collaboration.
- The **behavioural approach** is focused on changing risk factors and lifestyle behaviours.
- The **determinants approach** situates health and social problems in the broader social, structural and cultural conditions of our society and informs public health and health promotion approaches.
- The **health promotion approach** is the process of enabling people to increase control over, and to improve, their health. Health promotion work is strongly influenced by the knowledge derived from the determinants of health approach.
- The **public health approach** refers to all organised measures to protect health among populations, and to prevent disease, promote health, and prolong life among the population as a whole. Public health uses methods of epidemiology and biostatistics to inform health protection and prevention efforts. Three more specialised approaches have developed from the broader public health approach:
  1. **New public health** aims to learn from the political and practical experience of historical successes and failures in public health to achieve higher standards of health, particularly of those who have the least resources, to achieve a more just and socially responsible distribution of resources.
  2. **Ecological public health** emphasises relationships between the health of the planet and the health of populations, demonstrating the essential interdependence of people's health with the health of the planet.
  3. **Population health** studies a wide range of other data sources to understand the health of whole populations, alongside profiling the health of people in local areas. Further, population health emphasises the dual purpose of improving the health of the entire population while targeting reduction of health inequities among population groups. In order to reach these objectives, population health studies the broad range of factors and conditions that have a strong influence on people's health to inform the work of health promotion and primary prevention practitioners.

behavioural approach to health
Underpins the types of health promotion that focus on risk factors and lifestyle behaviours.

determinants approach
Sees health and social problems in the context of broader social, structural and cultural conditions of our society and informs public health and health promotion approaches.

health promotion approach
The process of enabling people to take control over those factors that determine their health.

public health approach
Social and political actions aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention.

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new public health
An explicitly social and political approach to health development that emphasises the translation of knowledge to action on the social determinants of health, intersectoral action to support health, healthy public policy, environments for health, sustainable development and equity in health.

ecological public health
The outcome of complex interrelationships and interdependencies between human beings, the determinants of health, and the broader environment in which they exist.

population health approach
An approach to health that aims to improve the health of the entire population, rather than individuals, and to reduce health inequities among and between specific population groups.

- *Indigenous approaches* see that one cannot separate health from life, social and spiritual relations and the environment.
- *Sociological approaches* study health and illness from social, political, economic and structural dimensions.
- *Spiritual approaches* conceptualise health decisions as the actions of a God or other ethereal force(s) beyond the control of the individual.
- *Cultural approaches* to health differ very widely. Most of the approaches listed here are based on Western systems but every culture has developed its own practices and beliefs about health, illness and disease. In our multicultural, diverse world, all health practitioners need to become culturally competent and acquire knowledge about culturally safe health care practices.
- *Popular or lay approaches* see that people define health in different ways according to their culture, experience and life situation. Health is related to personal expectations. Health and illness are not 'either/or' states because, in reality, people can feel quite healthy even though they may be living with an illness.

Each of these approaches has its own value, but no single approach is universally valid—indeed, there is overlap between many of the approaches. That said, no one approach is able to comprehensively define health in a way that would hold good for all people, in all communities, in all places.

Most of these approaches have a theoretical foundation. 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 gaining understanding of the theories underpinning these approaches 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 well-being. The next section provides a snapshot to get you started.

THEORIES OF HEALTH

There are many, many theories underpinning the various approaches to health. Of course, no theory stands alone—there is interaction between the ideas and concepts within these theories that inform how we think about health and well-being. A theory is a set of assumptions, or propositions, or hypotheses or accepted facts that are assembled to provide a plausible or rational explanation of the cause and effect of observed occurrences or experiences in the world. To become an accepted theory, those assumptions, hypotheses or propositions have been tested repeatedly to strengthen the internal and external validity of the theory. Theories are generally a set of abstract ideas, tested for their validity and generalisability.

The function of a theory is to explain the complexity of the world and predict what might happen if one or more important factors change—all in the simplest and most elegant way possible. Theories are usually based on a set of principles that can be applied to the

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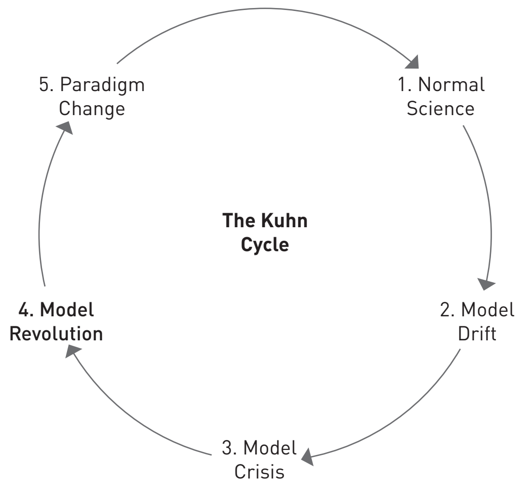
real world. Theory then can be established, or emerge, but all theories are subject to new knowledge and learning and may be subject to challenge.

Paradigm shifts in theory

Thomas Kuhn (1970) was a leading thinker of the 1960s and 1970s; his arguments about the 'structure of scientific revolutions' changed accepted wisdom about how new knowledge becomes accepted into new paradigms. A paradigm is a distinct form of thought patterns that gives shape to thinking with the sciences and social sciences. He argued that when new questions are asked of established or accepted data and ways of thinking about something, the paradigm shifts or changes. Figure 1.1 below is a simplified illustration of the cycle of paradigm change that Kuhn put forward.

Figure 1.1 Kuhn's cycle of paradigm shifts



Source: Thomas Kuhn.

To understand Kuhn's cycle, consider the bacteriology era of the nineteenth century that fundamentally changed our understanding of the causation of disease. In earlier centuries, miasmic theories of disease causation were considered normal science, but as bacteria and viruses were discovered using new scientific technology, miasmic theories were rejected, causing a theoretical revolution. Indeed, the model of treating disease was in crisis. So, the era of bacteriology was a scientific revolution that caused a huge paradigm shift in how we understand, diagnose and treat disease, and produced the curriculum that is taught to health professionals today.

In more contemporary life, we are seeing a paradigm shift in relation to climate change and the sustainability of the planet (see also Chapter 13). Paradigm shifts are often, but not always, characterised by conflict and debate as people defend positions or argue for the new scientific positions. Kuhn's work inspired scholars from around the world to see shifting

For more information on climate change, see Chapter 13

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landscapes in thinking and knowledge and analyse how the institutions of society have been affected or influenced by those shifts. The concept of a 'paradigm shift' has entered our lexicon and is used widely to describe changes in thinking that have occurred.

Building on the approaches to health earlier in this chapter, we now consider the theories of health that come from different types of science. One group of theories looks to the natural sciences because they share the same paradigm, or perspective, on science. These are:

- body: biological and biomedical theories look inside the body and generally come about through a hypothesis or group of hypotheses that have been supported with repeated testing of biological phenomena
- behaviour: behavioural approaches examine how lifestyle and risky behaviours impact on health
- mind: psychological theories attempt to explain social and cognitive phenomena, including social psychology, personality, attribution and many others.

Using the language of Kuhn, another group of theories comes from a different paradigm from those about body, behaviour and mind; those that look to the social and cultural sciences. These are:

- beliefs and spirituality: analysis of culture, religion and belief system reveal complex and powerful explanations for health and illness that invoke the supernatural or religious, or strong beliefs that bind people of a particular culture together. Cultural theories are developed by anthropologists who study cultural belief systems and practices to inform our understandings of cultures that differ from the mainstream in any society.
- sociological theories: are more likely to emerge from questioning about observations of the social world and the societies in which people live, and attempt to explain social phenomena.
- politics: brings a more political analysis to the explanation of health and illness.
- public health, population health and health promotion: draw on concepts and models from a range of theories including epidemiological, causal and ethical theories. Public health workers also develop theories of the determinants (including biological, behavioural, community and structural levels) and the distribution of disease across population groups. They then apply that knowledge, using implementation theories, to the prevention of disease and to improve the health of populations. Theories of politics including political culture, political ideologies, political philosophy, political science theories, and political systems are central to understanding health.

To understand a person's health status, professionals and community members always need to take account of people's own perspectives and their capacity to manage or control the challenges and changes in the environments surrounding them. As well, professionals need to understand the theoretical and conceptual understandings derived from the formal literature, and to use all these sources of knowledge in their judgments about how best to assist those consulting them for treatment.

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You will find that approaches to health are influenced by systems of beliefs and values about health and that some beliefs and values are given precedence over others. It is also the case that knowledge is not linear and can't be understood in silos of information. In other words, the chapters in this book illustrate that there is no single causal pathway to poor health or disease in a population (Tesh 1988).

PROFESSIONS' VIEWS OF HEALTH

The profession of medicine draws on natural science paradigms based on the science or practice of the diagnosis, treatment, and prevention of illness and disease. Similarly, nursing and the allied health professions are educated in modalities designed to treat disease or prevent its recurrence. Midwifery is entirely about the care of women during pregnancy, labour, and the postpartum period, as well as care of the newborn. The focus of these professions is largely on individualised care, so their views of health are predominantly about the health and well-being of an individual. Their work is mostly, but not entirely, based on their observation of diagnosable symptoms, which is why they are called clinicians.

Public health and health promotion professions draw on more structural and political paradigms to learn much more about the health of populations and ask why different populations have different rates of health and disease. They are concerned with activities that aim to provide conditions in which people can be healthy so their focus is on entire populations, not on individual patients or diseases. Many clinicians take up postgraduate studies in public health to broaden their understanding of health beyond the care of individuals.

As the study of health and illness added the expertise of social and political scientists to its natural science paradigm, we began to understand that the pattern of health and illness in populations cannot be explained, let alone influenced, by professionals from the health sector alone. Contemporary public health and health promotion therefore 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. As a result, we hope that this book will be used in university courses and in professional development not only in the health sector, but also in those sectors whose activities contribute to how the day-to-day organisation of our lives adds to, or takes away from, disease and disability years in the lives of individuals, groups and populations. Below we provide some examples of fields of study and practice that are vital for understanding and action on health. This is by no means an exhaustive list, but serves to illustrate how critical it is that public health and health promotion moves beyond the health sector to understand and work in new disciplines and frontiers.

Local government is increasingly involved in matters of health including the creation of safe and healthy places for people to live and work, planning schemes to manage where and how people live and work, a wide range of support services, mechanisms for residents to participate in decisions affecting the community, and planning for infrastructure such as transport and land use schemes. Increasingly, local government is responsible for public health and well-being plans and their implementation, and is increasingly involved in health promotion (see Chapter 7).

For more information on health promotion, see Chapter 7

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You will see in this book how urban and regional planning shapes the way our houses connect to our work, education and leisure, and what this means for people's physical activity, social relationships and engagement with nature.

The education sector is also critical for health. A person's level of education directly influences literacy, which includes health literacy, cultural literacy and scientific literacy as well as reading ability. Levels of education develop interpersonal and life skills, and are a major influence on pathways through life that contribute to good health such as being able to gain steady employment and live in stable housing, being an active community member, and being able to make healthy relationship and food choices, as well as choices about smoking and substance use.

In Chapter 13 we explain why the future of the climate and ecology is inextricably linked with new and potentially catastrophic patterns of health and illness in just a few generations' time. Therefore, ecologists, conservationists and those who develop new approaches to industry, power and transport will play key roles in preserving the health of the planet, which in turn is becoming the most powerful determinant of the health of people and civilisations.

Information technology is revolutionising the way we learn, work and play. It also changes the way medical records are kept and how, for example, the internet and smart phones and smart watches are being used in health promotion.

This book, and the broad field of public health, seeks to bring together a variety of professions, disciplines and communities to understand old health problems, and anticipate new problems, so that we can help create a better world for our children and their children.

THE POLITICS OF HEALTH

Throughout this book it will become clear that health is a highly political terrain. We have already seen in this chapter how paradigms in science promote and defend themselves, therefore becoming resistant to change. For example, the paradigms explaining health in terms of the body and mind are very different from those invoking more cultural and political factors. These are not unemotional decisions decided by rational debates about scientific evidence. On the contrary, we have seen that, according to Kuhn, paradigm changes are difficult and contested because they involve power and values that challenge accepted thinking. That is why many political struggles are played out over the health system, particularly at levels of government where different political philosophies determine the budgets for health programs and services.

In the nineteenth century, Rudolf Virchow, the German physician and politician, wrote:

> Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution (cited in Rosen 1979, p. 29).

His pronouncement still rings true today.

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Different governments, groups of health professionals and corporations have different ideas about the types of programs and services they want to fund, and politics drives the policies that sit behind those programs and services. Indeed, the dominance in Australia of the primary medical care model is a political outcome of the strength of medicine over the social model of health. More recently with conservative governments in Australia, we have seen attempts to wind back the universal system of Medicare and its coverage of essential health care for all Australians.

The political nature of health can be understood at three levels:

1. Health is political because, like any other resource or commodity, some social groups have more of it than others.
2. Health is political because its social determinants are amenable to political interventions. They are therefore dependent on political action (or, more usually, inaction) on the social determinants of health.
3. Health is political because the right to a standard of living adequate for health and well-being is, or should be, an aspect of citizenship and a human right (Bambra, Fox & Scott-Samuel 2007, pp. 48–9).

Health is intensely political because there are opposing ideological positions about how much responsibility governments should take with regard to health. The health system becomes a battleground between those who support universal access to high-quality health care and access to both hospitals and primary health care, and those who support greater provision by private interests. Many in public health are very concerned about attempts to wind back universal publicly provided health care through Medicare, Australia's health insurance scheme, because it provides a foundation of care for people throughout their lives, at an affordable cost. Another way to think about universal health care is that it aims to provide the right service, at the right cost, at the right time, by the right provider. These principles are about access, which in turn increases equity. Medicare is intended to increase both access and equity as Box 1.1 describes.

BOX 1.1 AUSTRALIA'S MEDICARE SYSTEM

Australia's Medicare system is a government run, universal, tax-funded, health insurance scheme where individuals' contributions are independent of health status. Australian citizens and most permanent Australian residents are eligible for Medicare, which guarantees all citizens access to a wide range of health services at little or no cost.

Medicare is funded through a mix of general revenue and a Medicare levy that is currently set at 1.5 per cent of taxable income with an additional surcharge of 1 per cent for high-income earners who have not taken private health insurance cover. People can choose whether to have Medicare cover only, or a combination of Medicare and private health insurance.

Medicare is built on the principal of universal access to health care because it is a key platform to improving the health of everybody, and provides equitably for disadvantaged and vulnerable groups. Universal health care is an essential responsibility of governments but it is increasingly a battleground of health policy between different sides of government.

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HEALTH EQUITY AND INEQUITY

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.

health inequity
Those inequalities in health deemed to be unfair or stemming from some form of injustice.

Health inequities arise from economic, cultural and social conditions and the way that a society's resources are distributed. This includes, for example, people's access to money, to health and social services, and to quality educational opportunities. Another way to think about health is to see in what ways health plays an essential role in human life and freedom for people to do the things they want to do with their lives (Sen 2004). These are issues of social justice. But not everyone has the same level of freedom to pursue their aspirations because where someone lives, and the emotional and economic support a person is provided with to pursue their ambitions, are not available to everyone in the same measure. When we talk about **health equity**, we open a conversation about issues of fairness and justice in the way a society arranges the social conditions of living and how those conditions create health or illness.

Social justice approaches to health are a necessary underpinning for health systems in order for priority to be put on the achievement of 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.

BOX 1.2 THEORETICAL CONCEPTS OF HEALTH EQUITY AND HEALTH INEQUITY

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 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.

health inequality
An observable, often measurable difference in health status between individuals, groups or populations, whatever the cause.

Inequality and equality are *dimensional* concepts, meaning they are terms that simply refer to quantities or distributions that are measurable. **Health inequality** is a term used to designate the (measurable) differences, variations, and disparities 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, and assert the need for public policy–driven solutions. Kawachi, Subramanian & Almeida-Filho (2002) make the point that not only is it important to understand the essential differences between the concepts of inequality and inequity, but it's also critical to appreciate that inequity is grounded in social injustice.

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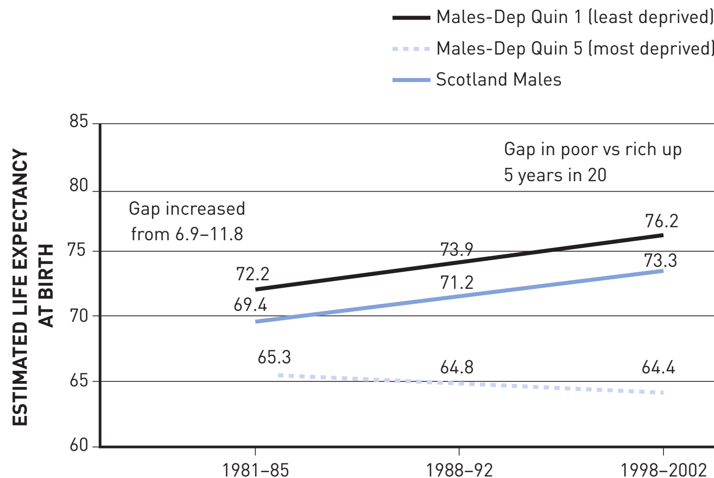
Health inequities, then, refer to those inequalities in health that are deemed to be unfair or stemming from some form of injustice. For example, people in disadvantaged areas experience health inequities because the access to and the distribution of services is unfair. Health inequities arise from the way people experience the conditions or factors that determine health and are very often preventable.

Consider Figure 1.2 below. The good news story it tells is that in Scotland the life expectancy for men rose from 69.4 to 73.3 over a twenty-year period. However, the graph also shows that the gap in male life expectancy between the most and least affluent parts of Greater Glasgow widened by five years from 6.9 years to 11.8 years, over those twenty years. Crucially, life expectancy of men in the least affluent area of Glasgow decreased.

Figure 1.2 The social gradient at work



Analysis of this graph shows that league tables of health based on average life expectancy can be misleading. A simple average can hide big gaps between least and most advantaged. It is possible for average life expectancy to increase, while the health of the worst off decreases. This shows the importance of looking at the gap, not the average.

Staying with Glasgow, Figure 1.3 shows the stark health inequalities in Glasgow in another way. It shows a drop in life expectancy of 2.0 years for men and 1.2 years for women for each station on the railway line between Jordanhill and Bridgeton. These are place-based inequities that follow the social gradient.

The work of the World Health Organization's Commission on the Social Determinants of Health (CSDH 2008) is discussed in Chapter 2. Research to Practice 1.1 is taken from its final report, which we commend to you for detailed descriptions of the ways in which health follows the social gradient.

For more information on the Commission on the Social Determinants of Health, see Chapter 2

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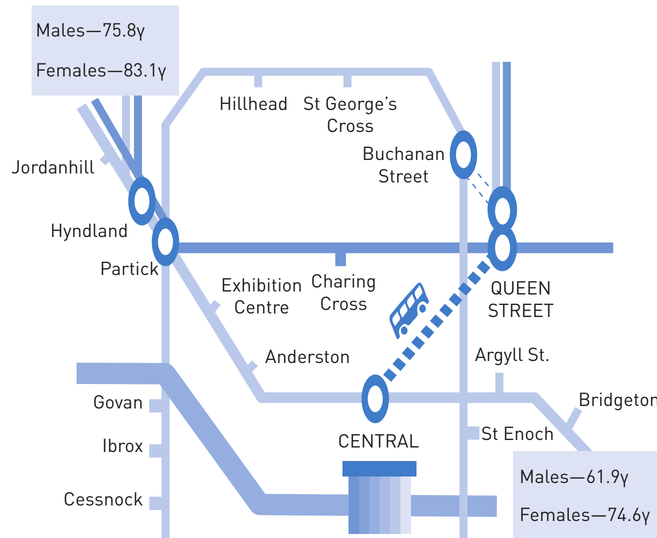
Figure 1.3 The social gradient by place



Life expectancy data refers to 2001–05 and was extracted from the GCPH community health and well-being profiles. Adapted from the SPT travel map by Gerry McCartney.

Source: McCartney 2010.

Research to Practice 1.1

Health and the social gradient

Marmot (2004) and his research team have researched the social gradient to illustrate how inequities are distributed. The poorest of the poor, around the world, have the worst health. Those at the bottom of the distribution of global and national wealth, those marginalized and excluded within countries, and countries themselves disadvantaged by historical exploitation and persistent inequity in global institutions of power and policy making present an urgent moral and practical focus for action. But focusing on those with the least, on the 'gap' between the poorest and the rest, is only a partial response. For example, in relation to under-5 mortality rates by levels of household wealth in five developing countries the message here is clear: the relation between socioeconomic level and health is graded. People in the second highest quintile have higher mortality in their offspring than those in the highest quintile. The social gradient is not confined to poorer countries. ... national data for some areas of the United Kingdom (England and Wales) for people classified according to levels of neighbourhood deprivation ... [shows] the mortality rate varies in a continuous way with degrees of deprivation. The range is large: the difference in mortality between the most and least deprived is more than 2.5-fold.

Source: World Health Organization 2008, Final Report, Commission on the Social Determinants of Health, WHO, p. 31.

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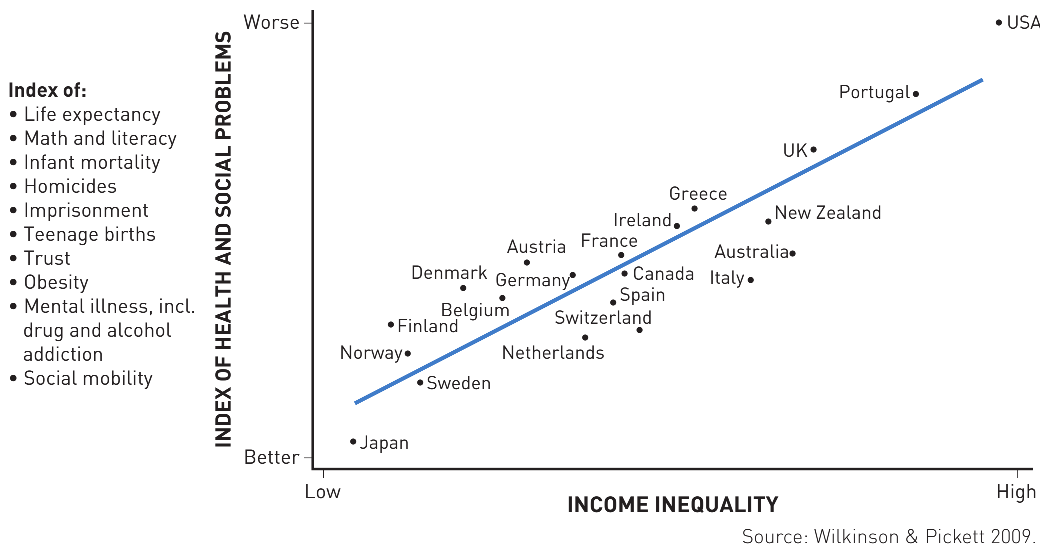
Moving to a larger scale, we recommend that you read *The Spirit Level* (Wilkinson & Pickett 2009). Here you will find multiple sources of evidence showing that, in developed countries, increased wealth does not lead to increased health. Rather, the critical factor is the way in which wealth is distributed. More equal countries, and states within countries, enjoy better health status than unequal states or countries. This holds true across a range of indicators and countries (discussed further in Chapter 8). Figure 1.4 shows how health and social problems worsen as income inequality increases.

For more information on indicators, see Chapter 8

Figure 1.4 Health and social problems are worse in more unequal countries



Source: Wilkinson & Pickett 2009.

So health equity and inequity are theories about how we as a society achieve, or not, fair health status between population groups, and the allocation of resources that permit equal or unequal access to health care, or broader economic allocations of those goods and resources that underpin good health, such as education and social welfare.

An illustration of the difference between inequalities and inequities is in the field of mental health disorders. People living with serious mental health disorders have a reduced life expectancy compared with people who don't live with mental health disorders. This is such a measurable difference. But is that difference in life expectancy related only to the illness itself, or is it also related to social conditions that are unfair? How much of that difference is related to chronic poverty and low socio-economic status and a stigmatised position in the social gradient? In other words, do people living with serious mental health disorders experience health inequities?

Certainly in the field of mental health, we need to work much harder on securing people's access to good care to ensure better continuity of care and improved outcomes from treatment. But given the stigma attached to mental health disorders, how are pathways

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to good care affected by stigma? To what extent do health literacy and education affect people's mental illness experiences? To what extent is there a trickle-down effect of racism, discrimination and social exclusion for people that creates poor mental health; and what kinds of social support are available to them? What is the impact of violence, sexual assault, drug use or homelessness on their care? Too often, people with mental health disorders become isolated, and experience income decline and loss of social contact, causing them to lack the kinds of social support that have such a profound influence on health. Thus, information about the mental health status of people is a much more complex story than that provided by morbidity and mortality measurements alone. There are profound social inequities for people with serious mental illnesses that also tell a story about the difficulties of living with mental illness.

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Chapter summary

Traditionally, people who study a Western clinical discipline are focused on learning about individual health problems and how to treat them, taking the role of scientist or expert. There are many approaches to understanding health from cultures both in Australia and around the world. Health professionals benefit from a good understanding of cultural differences and practices and how to practise from culturally safe perspectives. Health and public health are now reaching out to other fields and disciplines for their theoretical and practical insights because the health sector alone cannot guarantee to improve the health of populations.

The study of public health, the determinants of health, and health promotion, are about population levels of health and illness, and how to work with policies and programs that are directed at whole populations or communities. It emphasises working with communities and having a deep respect for people's health knowledge and their cultural and experiential wisdom. This respect for culture is essential across populations where there is a rich diversity in people's backgrounds, experiences and culture.

Understanding of the health of the most vulnerable and disadvantaged people of any society is made clearer when we think from a 'determinants of health' approach. Health professionals benefit from a good understanding of the determinants of health and illness so that they can work towards better health for populations as well as individuals.

Finally, to understand health, we seek to understand why and how health is both enhanced and compromised by politics as well as by adverse social, economic, environmental and cultural conditions. We know health and illness do not exist in a vacuum. Health is dependent on services ranging from access to sanitation, sewerage systems and clean water to housing, education and transport, as well as appropriate, affordable health facilities and personnel. It sounds like common sense, yet these foundations of health are not the norm for all people in our society so we examine them further in Chapter 2.

Discussion topics

1. In what different ways do you, members of your family, and your friends and colleagues define health? If you don't know, just ask them, and write down the key points that they make so you can compare.
2. What approaches to health are presented in an average week in the media?
3. What do you think you need to learn about health so you can be an effective practitioner?

Further reading

Baum, F. 2008, *The New Public Health* (3rd edn), Oxford University Press, Melbourne.

McMurray, A. & Clendon, J. 2014, *Community Health and Wellness, Primary Health Care in Practice* (5th edn), Churchill Livingstone, Sydney.

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Tesh, S. 1988, *Hidden Arguments, Political Ideology and Disease Prevention Policy*, Rutgers University Press, New Brunswick, NJ.

Useful websites

Australian Council of Social Services: www.acoss.org.au/policy/poverty

At this site, you will find the 2014 Report on Poverty in Australia and links to other reports about the impact of poverty on Australians.

Public Health Agency of Canada: What Determines Health: www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php

The information provided here sets out the various determinants of health and makes clear connections between action on the social determinants of health and population health.

World Health Organization, Commission on the Social Determinants of Health: www.who.int/social_determinants/thecommission/en

The WHO CSDH site is rich with information. It includes the background papers, synthesis reports developed for the Commission by its eight Knowledge Networks, and the final report of the Commission.

Oxford University Press Sample Chapter