Chapter 1

Health, Illness and Well-being:
An Introduction to Social Determinants of Health

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Topics covered

This chapter covers the following topics:

- an introduction to health, illness, well-being and disease
- determinants of health
- biological determinants
- environmental determinants
- social determinants of health
- gender, ethnicity and social class
- health inequality and social justice
- the social gradient

Key terms

behavioural determinants
biological determinants
determinants of health
disease
environmental determinants
ethnicity
gender
health
health inequality
illness
individual determinants
sex
sickness
social class
social determinants
social gradient in health
social justice
well-being

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Introduction

Health
There is no definite meaning of health. Its meaning can be different depending on individuals, social groups and cultures, and can differ at different times. However, the World Health Organization (1978, p. 2) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

The concept of **health** has different meanings to different people (Jirojwong & Liamputtong 2009; Wiley & Allen 2017). Each individual perceives and experiences health, illness and well-being differently from others (Jones & Creedy 2012; see also Chapter 2 in this volume). Some individuals see health as a general sense of well-being such as 'feeling good' (Winkelman 2009, p. 14). Health may mean being active and fit for some people. For others, health means having a balance in their lives, being productive or able to fulfil their responsibilities (Levin & Browner 2005; Taylor 2008; Jirojwong & Liamputtong 2009; Blaxter 2010; AIHW 2018). Additionally, members of different cultural groups may see health, illness and well-being differently (Winkelman 2009; see also Chapter 3).

In Australia, the notion that health is of primary importance is pervasive. This is reflected in the fact that health and illness are featured in all kinds of media. Often, there are reports or stories about health issues, health-related behaviours and experiences, the importance of fitness and health, new medical and scientific discoveries, healthcare services and government policies (Taylor 2008; Germov & Freij 2019; see also Chapter 13).

There are many things that can determine our health, illness and well-being. These range from societal influences to individual aspects such as genetic makeup as well as the healthcare to which we have access. These are referred to as the 'determinants of health' since they 'influence how likely we are to stay healthy or to become ill or injured' (AIHW 2016, p. 128; see section below on determinants of health and Chapters 2, 13 & 14). According to the Australian Institute of Health and Welfare (AIHW) (2016, p. 3), the health, illness and well-being of an individual comprise many aspects that 'result from complex interplay between biological, lifestyle, socio-economic, societal and environmental factors'.

I will take you through several important concepts. First, I introduce the meaning of health, illness, well-being and disease, followed by the determinants of health. Then I discuss relationships between health determinants, in particular the intersection of gender, ethnicity and social class. Last, I provide the social gradient in health and health inequalities.

Conceptualising health

Culture
A system of shared ideas, attitudes and practices that defines the social system of its members.

According to Keleher and MacDougall (2016a), it is impossible to find a universal definition of health which can be applied to all individuals, locations and time. As health embraces many aspects, it is tricky to say exactly what health means. The meanings of health are 'dependent on the context in which the term is used and the people who use it' (Keleher & MacDougall 2016a, p. 4). The concept of health can change over time, and it differs between individuals, families, social groups and **cultures** (Jones & Creedy 2012). Hence, health is 'socially and culturally constructed' (Taylor 2008, p. 5; Turnock 2016; see Chapter 2). The Australian Institute of Health

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and Welfare (2010, p. 3) defines health as an essential component of well-being. It is about how we 'feel and function'. Health is not simply about the non-existence of injury or illness, but there are degrees of wellness and health. Health is situated within broad social and cultural contexts (Baum 2016). The state of health of individuals in a society contributes to the social and economic well-being of that particular society. The following quotes suggest that health is defined differently depending on the contexts within which the definition is located.

> Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people (People's Health Movement 2011, p. 2).

> Health is not merely the absence of disease or distress; it is also a positive state of physical, emotional, mental, personal, and spiritual well-being and a balance with nature and the social world (Winkelman 2009, p. 18).

> Health is a personal and social state of balance and well-being in which a woman feels strong, active, creative, wise and worthwhile: where her body's vital power of functioning and healing is intact; where her diverse capacities and rhythms are valued; where she may decide and choose, express herself and move about freely (CHETNA 2011).

Keleher and MacDougall (2016a, pp. 5–6) outline different perspectives which can be used to conceptualise health. Several perspectives are relevant to this textbook (see Chapter 2). The lay or cultural perspective suggests that health is understood and interpreted differently by individuals depending on their experiences, life situations and cultural backgrounds. The biological perspective examines the role of genes and risk factors as well as their interactions with other health determinants (discussed later in this chapter). Closely related to the biological approach is the biomedical perspective. Within this approach, health and illness are perceived in terms of a person's medically defined pathology.

The behavioural perspective advocates that superior quality of life results from having good health, which is founded on risk factors and life-style behaviours. Health education is often the response to improving these determinants. The health promotion approach includes all of these perspectives and, in addition, pays attention to the powerful impact of a 'place' or location in determining health. Hence, we see projects such as 'Healthy Schools', 'Healthy Workplace' and 'Healthy Cities' (Baum 2016, p. 13; see Chapter 6). Research suggests that disadvantaged individuals such as poor people may have poorer health because they reside in places which are health-damaging (Baum 2016; Ratcliff 2017; AIHW 2018). The influence of location on health can be clearly seen in remote Indigenous communities in Australia and other parts of the world where important health facilities such as healthy food supply, clean water, good sewerage system, suitable accommodation and access to healthcare are insufficient or absent (Baum 2016; AIHW 2018). This also applies to poor people living in slums in many parts of the globe (Corburn & Riley 2016).

The Ottawa Charter for Health Promotion (WHO 1986) is considered the formal beginning of the new public health, which focuses on the social causes of illness and disease, health equity and social justice (Baum 2016; see Chapter 6). It suggests that social inequalities and health are situated within complex connections between social,

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economic, political and environmental determinants. As such, health is perceived as a 'complex outcome' which is influenced by factors including genetic, environmental, economic, social and political circumstances (Baum 2016, p. 17; Turnock 2016).

Disease, illness, health and well-being

Disease
A condition adversely affecting health that has measurable (clinical) symptoms.

Illness
A condition adversely affecting health as perceived by the individual in question.

Three main terms tend to be used to describe an individual's experiences of ill symptoms—'disease', 'illness' and 'sickness'. The term **disease** refers to 'medically defined pathology' (Blaxter 2004, p. 20). It is a malfunctioning of biological mechanisms (Jirojwong & Liamputtong 2009; Brown & Closser 2016; Wiley & Allen 2017). The term disease incorporates 'a set of signs and symptoms and medically diagnosed pathological abnormalities' (Baum 2016, p. 4). On the other hand, **illness** involves the subjective experience of ill health (symptoms and suffering) of an individual (Taylor 2008; Blaxter 2010; Baum 2016; Brown & Closser 2016; Wiley & Allen 2017). Individuals feel that 'something is not right with their health' (Jones & Creedy 2012, p. 4). Primarily, it is about how a person lives through the disease. Often, it involves personal, social and cultural reactions to a disease (Baum 2016; Brown & Closser 2016). Illnesses can disrupt people's lives, which may lead individuals to seek medical care and encourage behavioural changes so that the discomfort can be alleviated (Wiley & Allen 2017). An ailing person may have to rely on others for their basic needs in daily living (Spector 2017). Additionally, the subjective experience of illness is influenced by cultural contexts: 'There are culturally specific and culturally appropriate ways of being ill and expressing that experience' (Wiley & Allen 2017, p. 16; see also Chapter 3).

Sickness
The term is often used interchangeably with disease and illness; sometimes it refers to both. Sickness embodies a sociological meaning and is related to the concept of the 'sick role' theorised by Talcott Parsons.

Sickness is often used interchangeably with disease and illness and sometimes it refers to both. It, however, embodies a sociological meaning (Wiley & Allen 2017). Sickness is related to the concept of the 'sick role' theorised by Talcott Parsons (1951, 1979). According to Parsons, a sick person must fulfil 'a socially recognised set of expectations'. To be able to embrace the sick role, an individual must have a disease which is perceived as credible by the social group. The individual must also seek help in order to restore their health. The individual will be exempted from normal responsibilities including work, household chores or other duties which are expected of well persons (Wiley & Allen 2017).

Health, when situated within a biomedical framework of biological determinants, can be seen as 'the absence of disease or pathology' in a person (Taylor 2008, p. 10). It suggests that if the person does not have a disease, they are healthy. Taylor (2008, p. 10) contends that this view implies two main assumptions. First, there are two opposite states of being—an individual is either healthy or ill. Within this view, health and illness are seen as uniform and permanent concepts. Second, it implies that having good health is the norm and being ill is deviant. Thus, illness connotes 'abnormality, deficiency or impairment' (Scambler 2003; Blaxter 2010). As Blaxter (2004, p. 7) contends, 'the objective observation of a lack of "normality" meets a very ancient and universal tendency to see the sick person as in some way morally tainted or bewitched. Possibly, they are responsible for their own condition' (see also Chapter 4).

The concept of health as the absence of disease has been perceived as being 'too narrow' (Taylor 2008, p. 11). Health should be seen as a more credible and holistic

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condition (Levin & Browner 2005; Taylor 2008; Blaxter 2010; Wiley & Allen 2017). This is reflected in the definition of health proposed by the WHO (1948, p. 2), which advocates that health is a 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. This definition suggests that it is not only the biological functioning of individuals that determines the state of their health, but also their social and psychological conditions. These components do not function separately but interact with each other in complicated processes (Taylor 2008; Wiley & Allen 2017; discussed further in next section).

This view of health is reflected in the mental health area. There has been an attempt to define mental health in a way that moves beyond the focus on biological factors (Baum 2016). The Victorian Health Promotion Foundation's initial mental health promotion plan included the following positive definition: 'Mental health is the embodiment of social, emotional and spiritual well-being. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just' (VicHealth 1999, p. 4; see also VicHealth 2015).

The WHO definition of health incorporates the concept of **well-being**. This concept is seen as more expansive than that of health because it signifies an individual's sense of general contentment with life (Taylor 2008; Heil 2014; Wiley & Allen 2017). Well-being, Heil (2014, p. 41) suggests, refers to 'satisfactory states of being' that focus on 'positive connotations'. It underscores the 'subjective and experiential state of being in the world'. Well-being is used in a subjective sense in that there is nothing wrong, and can be completely separated from the objectively measured health or disease status of an individual (Heil 2014). People may possess a sense of personal well-being even when they are in very deprived situations; for example, during stressful life events or when confronted with acute or chronic disease (Wiley & Allen 2017). In a way, it could be said that well-being symbolises the opposite of illness (Jones & Creedy 2012). A sense of well-being in one society may be seen differently in another. For example, possessing a considerable expanse of body fat might be perceived as 'overweight' and requiring medical treatment in one society, but seen as a sign of excellent health in another (Wiley & Allen 2017, p. 15).

Well-being
A positive conceptualisation of health: feeling healthy, happy or doing well in life. It can be completely separated from the objectively measured health or disease status of an individual.

Case Example 1.1

Sophie

Sophie is a 78-year-old woman who has experienced a range of symptoms in the last few years. She suffers from severe tinnitus (ringing sounds) in both ears, and hearing loss in one ear. She has high blood pressure, which is being controlled by prescribed medication. Although she is slower with everyday activities and often has body aches and pains, she still eats and sleeps well. She is poor but she has good support from her children. She thinks what she has been experiencing is part of growing old. She does not think she is ill.

- What do you think about Sophie's idea of her health?
- In your view, should Sophie's conditions be categorised as illness? Discuss.

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Stop and Think

- What does health mean to you?
- What does illness mean to you?
- What does well-being mean to you?
- How do you know if someone is healthy or not?

Determinants of health

Situated within the new public health perspective, the health, illness and well-being of individual persons, groups and communities are determined by a diverse range of complex individual, social, cultural, environmental and economic factors and healthcare systems (AIHW 2016; Germov 2019; Hallet et al. 2019; Liamputtong 2019). This is referred to as determinants of health (Wilkinson & Marmot 2003; Marmot & Wilkinson 2006; Keleher & MacDougall 2016b; Oldroyd 2019). Conceptually, the focus of this perspective is on factors which could influence and determine the health of people, instead of on the state and outcomes of their health. It also underscores the prevention of ill health, rather than the measurement of illness (Taylor 2008; Keleher & MacDougall 2016b; Oldroyd 2019).

Determinants of health
A range of individual, social, economic, environmental and cultural conditions that have the potential to contribute to or detract from the health of individuals, communities or whole populations.

The **determinants of health** are characteristics or factors which can bring about a change in the health and illness of individuals and populations, for the better or worse (Keleher & MacDougall 2016b; AIHW 2018; Oldroyd 2019). Determinants of health include biological and genetic factors; health behaviours (such as risky life-styles, abuse of alcohol and cigarette smoking); socio-cultural and socio-economic factors (such as gender, ethnicity, education, income and occupation); and environment factors (including housing, social support, social connection, geographical position and climate) (see Chapters 2, 7, 9, 10, 11, 13 & 14). Resources and systems also have effects on the health and well-being of individuals and populations. These include access to health services, healthcare policy and the healthcare system (AIHW 2016; Sendall 2019; see Chapter 13).

Essentially, these determinants are connected with conditions, which can either improve or hinder individuals' possibilities of having and sustaining good health. Some conditions have a direct impact on the health and illness of individuals; for example, direct contact with heat or asbestos in their environment, cigarette smoking or lack of physical activities. Other conditions have an indirect impact on individuals. They can increase or reduce the influences of other factors, for example, when individuals are poor and cannot access suitable healthcare (Oldroyd 2019). These conditions can interact and function in complex ways. For instance, when people do not have good health, they may not be able to participate in employment or physical activities. This in turn will have further impact on their health (Oldroyd 2019).

According to the Australian Institute of Health and Welfare (AIHW) (2010, p. 64), health determinants can be perceived as a 'web of causes'. They can also be described

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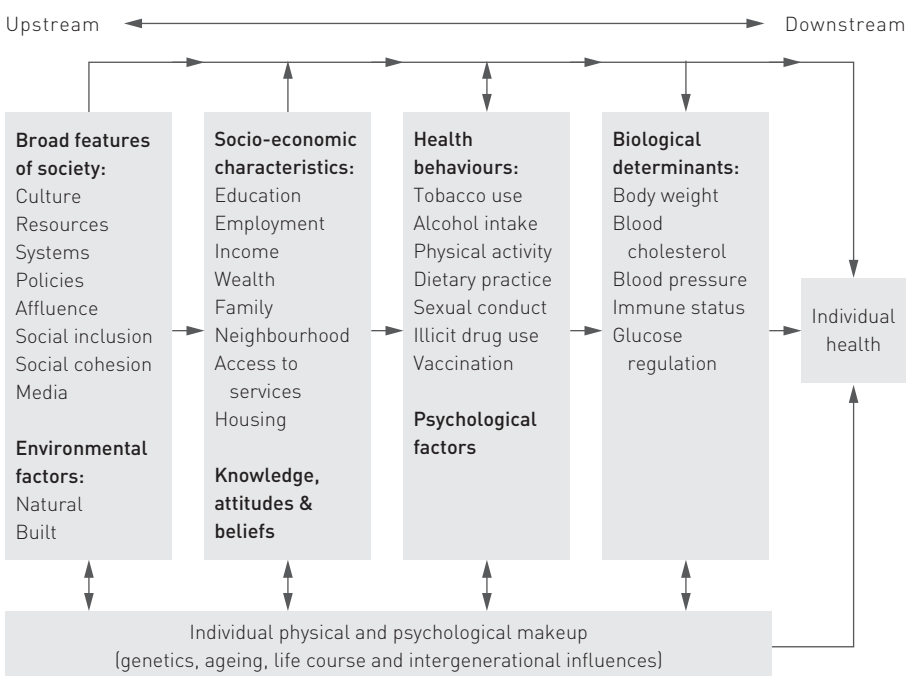
as part of broad causal 'pathways' which can influence health. Figure 1.1 presents a conceptual framework which shows the complex relationships of health determinants. The determinants are divided into four main categories. The direction of influence moves from left to right; that is, from the 'upstream' factors (such as culture, resources and affluence) to more 'downstream' or direct influences (such as body weight and blood pressure). The figure illustrates how one broad category (the broad features of society and environmental factors) can determine the nature of another main group (individuals' socio-economic characteristics, such as their level of education and employment). Both these broad categories in turn have impact on individuals' health behaviours, their psychological state and safety. These can then affect biomedical components, such as body weight and blood pressure, which have further health effects through different pathways. Along the different paths and states, these various factors interact with the genetic composition of the individuals. It should be noted that the direction of these influences can occur in reverse. For instance, an individual's health can have an impact on their levels of physical activity, employment status and wealth.

Health-promoting conditions can be divided into four main categories from the upstream factors such as ecosystem viability, equitable public policies and convivial communities, through to health-promoting mediating structures, for example caring relationships and service to others, through to health life-styles such as town planning to promote physical fitness and on to community-managed health services. It is argued that equitable public policies, for example, do much to promote healthy life-style choices (see Chapter 6).

Figure 1.1 Determinants of health



Adapted from AIHW (2010, p. 64); see also AIHW (2018, p. 6)

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Case Example 1.2

Samantha

Samantha, a three-year-old child, was born into a poor family and lived in a remote part of the country. One day, while running in the street with her older brother, she was pierced by a sharp bamboo stick that was discarded on the ground. Her mother bandaged the wound. Several days later, the wound became infected. Samantha began to feel pain in her groin and had fever. Her mother tried to manage Samantha's pain and fever with whatever she had at hand. However, Samantha became very unwell so her mother took her to a hospital, which was many kilometres away. Tragically, Samantha died a few days after being admitted to hospital (adapted from Werner 1997).

Stop and Think

- What do you think contributed to Samantha's tragic death?
- Could her death have been prevented? How?
- Who or what should be blamed for her death?
- Was death equally likely to occur if Samantha had been born into a more affluent family and lived in an urban area like Melbourne or Perth?

Intersections of individual, environmental and social determinants of health

As discussed in the previous section, health determinants interact in a complex way. It is important to examine some of the interrelationships between the three major determinants which play an important part in the health, illness and well-being of individuals. These are individual (biological and behavioural), environmental and social determinants.

Individual determinants
The individual characteristics and behaviours of a person. Individual determinant examines how particular characteristics and behaviours of an in individual influence their health outcomes.

Individual determinants

Individual determinants refer to the individual characteristics and behaviours of a person, including how particular characteristics and behaviours of an individual influence their health outcomes. There are two basic types of health determinants that link to an individual determinant: biological and behavioural determinants.

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Biological determinants

Biological determinants
The inner physiological aspect of health and disease. Genes play a crucial role in underlying biological differences between individuals.

The **biological determinants** of health and disease include a diverse range of 'heterogeneous, intra-individual factors' which push, intervene or mitigate the passages towards health or disease of an individual (Swinburn & Cameron-Smith 2009, p. 248). Genes play a crucial role in underlying biological differences between individuals, but they also interact with other social and environmental components which influence the health and disease of persons (see examples below) (Swinburn & Cameron-Smith 2009; Fleming & Tenkate 2015; Bartley 2016). According to Swinburn and Cameron-Smith (2009, p. 248), 'the genetic and physiological systems within the body are dynamic, complex, and highly interconnected, with whole systems balancing and competing against each other' to achieve homeostasis. This is very similar to the complex processes of the social and environmental system outside the physical body of the individual.

This can be seen in the case of HIV. HIV is dispersed in three ways: through sexual intercourse, blood transfusions (including through the use of needles and syringes), and from mother to child (Vaughan 2009; AIDSInfo 2017). While everyone can be infected with HIV, there are biological factors which increase an individual's susceptibility to infection. For instance, if an individual has another sexually transmitted infection (STI), such as chlamydia or gonorrhoea, the risk of becoming infected with HIV during sex is likely to be higher. If an individual has a blood disorder (and needs regular blood transfusions), they are at higher risk of contracting HIV. If a woman who is infected with HIV has health problems during pregnancy and breastfeeds her baby, there is a greater chance that the infection will be transmitted to the baby. The risk of HIV infection is also connected with the behaviours of individuals; for instance, having multiple sexual partners and having sex without a condom. Sharing equipment used for injecting drugs is a high-risk behaviour. Hence, although the biological factors are important, a focus on only biological risk factors will not stop the spread of HIV in populations (Vaughan 2009; see also Chapter 2).

Three biological determinants that play a role in the health and illness of individuals are race, sex and age. However, these are intertwined with social and environment determinants. Sometimes, it can be difficult to differentiate between the biological and other social and environmental conditions that determine people's health and illness.

Age is a clear biological determinant of the health of human beings (Miller 2009; West & Bergman 2009). Genes may have some impact on the causation of disease (Keleher & Joss 2009; Passarino et al. 2016). However, for many diseases the causes are environmental. For example, cognitive functioning decline among older people is not only the result of being old. It may also be affected by lack of practice, illness (such as depression), behaviours (such as the use of medications), psychological components (such as lack of confidence, motivation and low expectations), and social aspects (such as isolation and loneliness) (Cyarto & Batchelor 2019). (Race and gender will be discussed in a following section, under the social determinants of health.)

Biological determinants are fixed individual attributes that the person cannot control; for example, a family history of disease and heritable conditions, such as

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sickle cell disease. Some of these factors have an impact on the health of certain groups more than others. For example, sickle cell disease is especially common among people whose ancestors came from sub-Saharan Africa.

Behavioural determinants

Behavioural determinants
Personal attributes or behaviours that influence an individual's risk of experiencing poor health.

Individual behaviours play an important role in the health outcomes of a person. **Behavioural determinants** of health include personal characteristics (beliefs and values) and behavioural dispositions which can escalate or reduce good health, or the risk of poor health outcomes. These include protective or risk behaviours such as hygiene, exercise, diet, sexual practices and alcohol and other drug use (licit and illicit), as well as responses to health issues such as help-seeking and compliance with healthcare and medical treatment (Bidewell 2019; Hallet et al. 2019). According to McGinnis and colleagues (2002), the behavioural choices of an individual are a major determinant of health. They contend:

> The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health (p. 82).

Behavioural factors can increase our risk of both chronic diseases and infectious diseases. For example, cigarette smoking increases the risk of chronic diseases such as heart disease and lung cancer, while unprotected sex increases the risk of sexually transmitted infections such as HIV. Unlike the biological determinants of health, behavioural determinants are modifiable characteristics, and an individual has some control over their health and well-being.

Some characteristics of an individual, such as knowledge, attitudes and skills, have a great impact on their health behaviours. These determinants can assist an individual to preserve healthy behaviour and obtain the best possible health outcomes. Health promoters are particularly interested in influencing the knowledge, attitudes and skills of individuals in order to achieve long-term improvements in the person's health behaviour (see Chapter 6).

Environmental determinants

Environmental determinants
Physical environmental factors, such as climate and location, which can affect the health of individuals.

The important connection between the **environment** in which individuals live and their health and well-being has long been observed (McMichael 1993, 2000, 2001; McMichael et al. 2003; Nicholson & Stephenson 2009; Griffith et al. 2010; Fleming & Tenkate 2015; Ratcliff 2017; Hallet et al. 2019). Historically, environmental dangers to people's health tended to be related to issues of underdevelopment such as poor water quality, poor housing and the absence of sanitation. Although these 'traditional' threats have been managed successfully in more affluent areas within developed countries, there are still problems among socially disadvantaged and vulnerable groups of developed nations, and in the poorer countries of the globe

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(Nicholson & Stephenson 2009; WHO 2017a; Hallet et al. 2019). This can be seen clearly in the environmental threats faced by some Indigenous people in Australia and elsewhere (Bertolatti et al. 2015; WHO 2017a). 'Modern' threats have emerged because of overconsumption and overdevelopment in developed nations (WHO 1997; Ratcliff 2017). These modern threats, including climate change, have become global hazards (McMichael 1993, 2000, 2001; McMichael et al. 2003; Eisenberg et al. 2007; Nicholson & Stephenson 2009; Fleming & Tenkate 2015; Baum 2016). Australia is a developed nation which is highly susceptible to the impacts of climate changes (Kennedy et al. 2010; Baum 2016; Talbot & Verrinder 2017; see Chapter 11).

Global climate changes can impact on many aspects of human life and health (Watts et al. 2015; Ratcliff 2017). Thermal extremes, such as heatwaves, can cause difficulty for many people, in particular the very young, very old, very poor and very sick (Goldsworthy et al. 2009; Nicholson & Stephenson 2009; Baum 2016; Talbot & Verrinder 2017). In 1959, a four-fold increase from the normal mortality rate resulted from a prolonged heatwave in Melbourne (McMichael 1993). Climate change and global warming are directly connected with the dispersion of infectious disease vectors and pests as well as with reduced food production (Talbot & Verrinder 2017). And this of course will affect people from poor areas and nations more than those from wealthier areas and locations with better resources (Hancock 1994; Baum 2016; Ratcliff 2017). Poor people who live in poor nations are disproportionately burdened by environmental problems and the related health impacts (Hancock 1994; Baum 2016; Ratcliff 2017). The WHO (1997, p. 198) puts it clearly: 'Impoverished populations … are at greater risk from degraded environmental conditions. The cumulative effects of inadequate and hazardous shelter, overcrowding, lack of water supply and sanitation, unsafe food, air and water pollution and high accident rates impact heavily on the health of these vulnerable groups'.

Increasingly and globally, we have witnessed more environmental hazards and the health impacts of climate change resulting from human behaviours (Hallet et al. 2019). Severe drought, flooding, storms and extreme temperatures have become very common in recent years. This is what we have experienced in Australia—the Black Saturday bush fires in Victoria in January 2009, the widespread floods in Queensland, New South Wales and Victoria in January 2011, Cyclone Yasi in north Queensland and Cyclone Carlos in Darwin in February 2011, and extreme changes of weather in many Australian cities in 2017 and 2018 (see Chapter 11).

Social determinants of health

Not all illnesses are caused by biological and environmental agents. The health and well-being of individuals is also influenced by a number of **social determinants**. There are a number of factors, including social, cultural, economic and political, which can impact health (WHO 2015; AIHW 2018). This position goes beyond the restricted view of biological and genetic aspects of health (Wilkinson & Marmot 2003; Marmot & Wilkinson 2006; Marmot 2010; Keleher & MacDougall 2016b). Social determinants of health are described by the WHO (CSDH 2008, p. 1) as 'the

Social determinants
A number of factors, including social, cultural, economic and political, which can impact on the health of individuals.

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circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live or die are, in turn, shaped by political, social and economic forces' (see also AIHW 2018, p. 179; WHO 2017b). Social determinants of health are created by 'the multilevel distribution of money, power, and resources' (Compton & Shim 2014, p. 4). This social condition is the most influential foundation of good health or illness (Cockerham 2013). Thus, social determinants can be perceived as 'causes of the causes—that is, as the foundational determinants which influence other health determinants' (AIHW 2016, p. 129; Marmot & Bell 2016). They are also the root cause of health inequities, the unjust and preventable discrepancies in health status that we have witnessed within and between nations (WHO 2017b; see also Chapter 14).

Social determinants of health are 'attributable to the structure and functioning of society' (Reidpath 2004, p. 22). For example, transportation can be seen as a social determinant of health since it can impact on individuals' physical activities, and this in turn can influence their nutritional intake and cardiovascular condition. Social expectations regarding sexual behaviours are also social determinants of health as they can influence individuals' approaches to risky sexual conduct. This can lead to marginalisation, stigma and discrimination (Reidpath 2004; see also Chapter 14).

Stop and Think

Have you ever looked at the homeless men who sleep on the local park bench with a blanket to cover their bodies, while their possessions are kept in some plastic bags next to them? When they wake, they tend to talk to themselves and do not seem to care about others around them. Have you ever thought about how they came to be like this? Have you been curious about what type of journey they have been through in their lives and what it would have been like for them before this misfortune, such as when they were somebody's son, father, husband or colleague? To develop an understanding of the life of these men necessitates some understanding of the social determinants of health (adapted from Lawn 2008, p. 36).

Gender
Socially and culturally constructed categories reflecting what it means to be 'masculine' and 'feminine', and associated expectations of roles and behaviours of men and women.

Sex
A biological construct based on biological characteristics that enable sexual reproduction.

Ethnicity
A shared cultural background which is a characteristic of a group within a society.

Important social determinants of health are related to positions of social life including gender, ethnicity and social class (Reidpath 2004; Cockerham 2013; Hill 2015; Schofield 2015). **Gender** is understood as a social construct, referring to the distinguishing characteristics of being a woman or a man (Schofield 2015; Stuber 2016; VicHealth 2017; Broom et al. 2019). Gender can be seen as the full range of personality traits, attitudes, feelings, values, behaviours and activities which are ascribed to women and men by the society in which they live (Stuber 2016; see also Chapter 9). It is different from **sex**, which is a 'biological construct premised upon biological characteristics enabling sexual reproduction' (Krieger 2003, p. 653; Stuber 2016). **Ethnicity** refers to a shared cultural background; it is a characteristic of a group within a society (Stuber 2016; Julian 2019). Ethnicity includes dimensions other than biological determinants (referred to as race). These include social, cultural and economic factors. Ethnicity is now accepted as a more appropriate

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determinant of health than race (Jones & Creedy 2012; Schofield 2015). Gender and ethnic inequalities in health have been observed in many societies, including Australia (Hill 2015; Bartley 2016; Casado et al. 2016). **Social class** refers to the position of a person in a 'system of structured inequality' which is grounded in the unequal distribution of income, wealth, status and power (Stuber 2016; Germov 2019). Income, poverty and wealth are closely connected with health; people who live in poverty are likely to have worse health status than those who are better-off (Wilkinson & Marmot 2003; Marmot 2010; Cockerham 2013; Mackenbach 2015; Schofield 2015; Baum 2016; Marmot & Bell 2016; Germov 2019). The Australian Institute of Health and Welfare (AIHW 2018, p. 256) states that 'people from poorer social or economic circumstances are at greater risk of poor health, have higher rates of illness, disability and death, and live shorter lives than those who are more advantaged' (see also Mackenbach 2015; Ratcliff 2017; Chapter 7).

Social class
The position of a person in a system of structured inequality; it is grounded in unequal distribution of income, wealth, status and power.

None of these social determinants exist in isolation (Reidpath 2004). They intersect in a way that can create inequalities in health among people (Hill 2015; Schofield 2015). For example, women from a low socio-economic background are likely to be in poorer health than those from a higher social class (Baum 2016; Germov 2019). Men from ethnic minority groups and lower social classes are likely to be disadvantaged in terms of health and well-being in comparison to white Anglo-Celtic men with higher incomes (Jones & Creedy 2012; Julian 2019). We have witnessed ample examples of these interrelationships. The most influential indicator of health inequalities is life expectancy at birth. Between 2010 and 2012 in Australia, life expectancy was 69.1 years for Indigenous males and 73.7 years for Indigenous females—10.6 and 9.5 years less than for their non-Indigenous counterparts (AIHW 2018). Indigenous Australians also fare worse in health issues. The health inequalities of Indigenous Australians are the consequences of 'poorer socio-economic status, long-standing marginalisation from mainstream society and healthcare and, in many instances, geographical location and isolation' (Taylor 2008, p. 18; see also Genat & Cripps 2009; MacDonald 2010; Saggers et al. 2011; Chirgwin & D'Antoine 2019; Gray et al. 2019; Chapter 8).

Social gradient in health and health inequalities

As we have witnessed, a number of circumstances and conditions have created basic inequalities that not only contribute to the ill health of people, but establish a recurrence of adverse physical and mental health consequences for many individuals and groups within the current socio-cultural, economic and political contexts around the globe including in Australia (Bartley 2016; WHO 2017b). As such, there exists health inequality among populations. This section discusses two issues that are relevant to inequalities in health among individuals, communities and nations.

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Social gradient in health

The health status of people coincides with a social gradient. Those who are situated lower on the ladder of the social hierarchy have a shorter life expectancy and greater risk of ill health than those who are higher up the social ladder (Marmot & Bell 2016). Individuals with a higher position in society will enjoy better health outcomes, both physical and mental, than those with a lower position (Fisher & Baum 2010; Compton & Shim 2014; AIHW 2018; Oldroyd 2019). The nature and magnitude of this social gradient differs between nations but it usually includes wealth, income, education, occupation, gender and ethnicity as well as area of residence (Marmot & Bell 2016).

Social gradient in health
Differences in social status that lead to different health outcomes. Individuals who are lower in the social hierarchy tend to have worse health outcomes than those located at higher social levels.

The **social gradient in health** impacts on the lives of people in both rich and poor countries. Within Australia and other western countries, the social gradient not only affects people from lower socio-economic backgrounds but also those in marginalised groups, including Indigenous people and people from culturally and linguistically diverse backgrounds including migrants and refugees (Shepherd et al. 2012; Castañeda et al. 2015; Moore et al. 2015; Khan et al. 2017; AIHW 2018). The social gradient in health has a significant impact on those in poorer areas of the globe. The greater the social disadvantages, the worse health will be the result (Oldroyd 2019). This means that 'not only the poorest but the majority have worse health and shorter lives than the best off in society' (Marmot & Bell 2016, p. 238).

Health inequality, health inequity and social justice

Health inequality
'Health differences' which are closely connected with social disadvantage and advantage.

Health inequalities refer to 'health differences' which are closely connected with social disadvantage and advantage (Braveman 2016, p. 38). This inequality disproportionately influences the health of the most disadvantaged members of society. Due to their low levels of wealth, prestige, influence or acceptance in society, people who are socially disadvantaged are adversely affected by health inequalities. These people include individuals from low-income backgrounds, members of ethnic minority and sexual minority groups, people with disabilities, women and many community groups who have historically been marginalised, discriminated against or excluded from others. Often, health inequalities are the consequences of social inequalities. Generally, those from more advantaged groups will have better health than those from disadvantaged groups (Keleher & MacDougall 2016a; AIHW 2018). Health inequality unfairly impinges on the health of people in poorer countries (Turnock 2016). This inequality has contributed to the psychosocial burden of many people (Kawachi & Kennedy 2006; Cushing et al. 2015).

Intrinsically, health inequalities are interwoven with health inequities (Braveman 2016). Health inequities refer to inequalities in health which are presumed to be unfair or arising from some kinds of injustice (Keleher & MacDougall 2016a). For

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example, people with disabilities and those from culturally and linguistically diverse backgrounds experience health inequities because of inadequate or lack of access to healthcare; people living in rural areas confront health inequities due to the unfair distribution of health services. In order to reduce or eliminate health inequalities, we must move toward health equity.

As inequalities are the consequence of inequitable societies, they are addressed through the concept of **social justice** (Braveman 2016; Taket 2019). It has been suggested that social justice approaches to health are crucial for public health and any healthcare system, so that individuals will have the right to good health outcomes (Wilkinson 2005; Wilkinson & Pickett 2009; CSDH 2014; Keleher & MacDougall 2016; see also Chapter 5). Justice means an equitable distribution of burdens and benefits among populations. Injustices occur when a burden unwarrantedly impacts on only some individuals and groups, and they lack access to benefits to which they are entitled (Turnock 2016).

Social justice
Systemic and structural social arrangements that improve equality. They include the fair distribution of resources, equal access to opportunities and rights, and protection of the marginalised and vulnerable.

Stop and Think

Consider the following examples. What do these tell you about our society and our own values?

- Rachel is an old woman who has been widowed for more than 10 years. She has little education and has always been poor. She does not own her own house, and has been renting a house in a suburb in Sydney. Recently, her lease was terminated because the owner wishes to renovate the house and increase the rent. Rachel does not have another place to move into and it has been very difficult to find rental accommodation in Sydney.
- Due to some difficulties in his life, Jack has become an alcoholic. He has been drinking heavily recently and, as a result, has been asked to leave his job. He is separated from his wife and two young children, and has been living on his own in a small flat. Because of his drinking problem and the difficulty he has caused his family, his colleagues and social network do not wish to have anything to do with him. He has virtually lost all of his social support.

Case Example 1.3

Barriers to breast cancer screening program among Thai migrant women

Early breast cancer detection is recognised as a common way to prevent breast cancer. However, the general trend in terms of numbers for screening for breast cancer among Asian women (e.g. from Malaysia, Iran, Jordan and China) is

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relatively low. It has been shown that less than 20 per cent of these women use the programs for early detection. The main reason for the low participation rate is the cultural attitude towards screening practices, especially shame from exposing breasts to strangers. However, there may be other factors that prevent migrant women seeking care to prevent breast cancer.

In a study with Thai migrant women in Melbourne, Suwankhong and Liamputtong (2018) showed that there were many barriers that prevent Thai migrant women from attending early breast cancer detection programs involving mammography, although the program was seen by the women as important. The women in this study had little familiarity with the health service systems in Australia. They expected to receive medical services at a single health location or facility, as this was the system they were familiar with in Thailand. Also, screening services were often located too far away from their areas of residence. Due to their low incomes, many women did not have a car, and it was difficult for them to travel to different healthcare facilities. Because of these difficulties, the women lacked interest in the program or were unwilling to find out further about the screening facilities that might be available.

The authors also found that language problems prevented many women from attending breast cancer screening programs. Most women had limited proficiency in English and were unable to communicate effectively with healthcare providers. They were unable to understand medical terms that would help them understand symptoms and illnesses in the necessary detail. Interpreters were not always available. When an interpreter was provided, the women were not satisfied with the interpreter nor with the interpretations. The interpreters were said to provide unclear explanations. They were said to deliver only very superficial health information. The women had no confidence that the interpreters explained what the doctor had actually told them. Often, the interpreters were not Thai. A Lao interpreter might be used, who did not possess a good understanding of the Thai language and culture. The women believed that this could create poor understanding of the issues and might also give them wrong recommendations for health practices. The women in the study sought to remedy this by consulting friends, co-workers and family members. This study suggested that language barriers are an important factor concerning the use of screening programs for breast cancer among Thai migrant women.

This study revealed that although breast cancer screening is seen as the best way to reduce deaths from breast cancer among women worldwide, there are many barriers to Thai migrant women using these programs. It is important for healthcare providers to understand their perceptions, experiences and living situations. This will lead to the provision of appropriate health prevention programs that will increase accessibility and better meet the circumstances of migrant women.

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Reflection Exercise

> Of all forms of inequality, injustice in healthcare in the most inhumane.
>
> (Martin Luther King, cited in WHO 2015, p. 1).

Below is an example of how social determinants of health can significantly impact healthcare costs in the US. Homeless people who are un- or under-insured tend to forgo preventive care and rely on the emergency room to deal with major health issues. Once their acute conditions are addressed, recovery is hampered by a paucity of stable housing and constrained access to follow-up care. Furthermore, these conditions might interfere with mental health issues and substance abuse. The consequence is an immense rate of complications that require costly re-hospitalisations, and little or no improvement in overall health or quality of life in the end.

Witnessing the meanness and inefficiency of this cycle, ShelterCare, a non-profit human services organisation in Eugene, Oregon, looked for change. The ShelterCare Medical Recuperation program, a medical respite care program which determinedly enhances well-being while reducing costs by integrating SDOH into the care of homeless people was developed in collaboration with Community Health Centers of Lane County (federally qualified health centers), Trillium Community Health Plan, the local coordinated care organization, and PeaceHealth Sacred Heart Medical Center, the local hospital. This 30-day program provides residents a safe, stable housing environment to assist them to recover. At the same time, a community health worker provides medical care coordination and an on-site case manager helps residents connect to community resources to help them regain long-term stability.

Phil, a homeless man, went to the hospital emergency department with an infected wound. After receiving critical medical treatment, the hospital referred him to the ShelterCare program, where he was provided with a small flat and three meals a day. The medical caregiver on site provided medications, changed dressings and organised follow-up appointments and transportation. She helped Phil establish care with a primary care provider. He had an untreated mental health issue and a substance abuse problem, and was referred to both counselling and an addiction treatment program.

At the same time, a case manager advocated for Phil with other social service and government agencies, assisting him through the process of applying for food stamps, Social Security, Medicaid, rental assistance, unemployment benefits and other services for which he might qualify. Phil was given a bus pass and ShelterCare staff took him shopping for toiletries and clothing. He participated in on-site training workshops that helped him create a resume, apply for jobs and gain knowledge about basic budgeting skills.

Although at the end of his month-long stay, Phil still had much work to do to regain full stability, he was one of the 80 per cent of program participants who left the program to move into permanent housing. By addressing the social determinants of health rather than continuing the cycle of emergency department visits, Phil's coordinated care costed 34 per cent less while helping him (and the greater community by extension) make progress toward a better quality of life.

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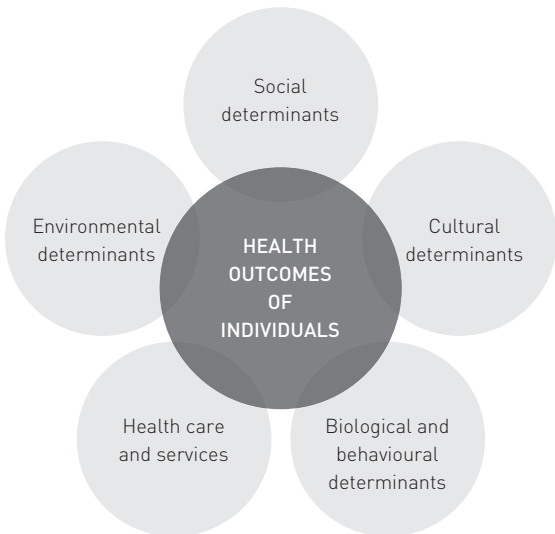
Although the ShelterCare program is focused specifically on those experiencing a predetermined set of conditions (homelessness and the need for acute recovery assistance), it shows both the value and feasibility of an outcome-based, SDOH-integrated network approach to healthcare for all (Rohwer 2018).

- What does this case study tell you about the social determinants of health?
- Would this case be applicable in other social contexts, like in Australia? How?
- What other social issues might we be able to adapt this framework to, to reduce health inequalities and social justice in our society?
- Considering the determinants of health model given in Figure 1.2, how can we address health inequalities in population groups in our society?

Figure 1.2 Determinants of health



Summary

Health, illness and well-being are inevitable aspects of our lives and have always played a part in the life of all human beings. However, the concepts of health, illness and well-being are socially and culturally constructed because individuals and cultures see health, illness and well-being differently. Diverse factors can have an impact on the health, illness and well-being of individuals, groups and

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populations. These determinants of health include biological, environmental, social, cultural and economic factors. These determinants can affect how healthy or sick an individual can be. Within the social determinants of health, there are three crucial social structures which can affect people's health and well-being. These are gender, ethnicity and social class. These three factors do not operate in isolation but, rather, interrelate to the extent that they create inequality in health.

Tutorial exercises

1. Form a group of five with your peers in the class. Each of you writes down as many definitions of health as you can. Then compare your answers. Are there similarities in your definitions? Are they different? Discuss the similarities and differences that you have noted in the group, and how they have come about.
2. After finishing this chapter, walk around the university campus and note any determinant that can make you healthy or ill. What have you noticed?
3. It has been suggested that women live longer and men die sooner. What is your view about this suggestion? Is it true? What would be the determinants of this difference?
4. As a group, watch the documentary *The Shape of Water* (2006) (available online: http://www.theshapeofwatermovie.com). Discuss the possible determinants that can create inequalities and social justice in different groups of people.

Further reading

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Websites

www.unep.org/

This is the website of the UN Environment Program (UNEP). It provides a number of resources regarding environmental issues; for example, urban issues, waste, water quality, sanitation, air quality, climate change and ozone depletion.

www.who.int/social_determinants/en/

This is the website of the WHO's Commission on Social Determinants of Health. It is a good source of discussions on social determinants and provides crucial background papers and reports as well as examples of actions in relation to social determinants.

http://www.phmovement.org/

The website of the People's Health Movement provides discussions about health and inequalities in health. It contains information about health networks and activists who have concerns about the inequalities and inequities in health.

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