Developing values, evidence and advocacy to address the social determinants of health

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The long-awaited Report of the WHO Commission on the Social Determinants of Health was released on 28 August, setting out directions for tackling the inequalities in health that have been widely documented within and between countries. The report, titled *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health,*[1] is a lucid and passionate document. It lays out an agenda for action across a dozen areas, ranging from conditions of living during early years, through to the quality of the natural and built environment, working conditions, market responsibility, gender equity and political empowerment.

For health promoters in Australia and New Zealand, the Commission's report lends strong support to a focus on equity in health, and hopefully it will be a valuable resource for advocacy to achieve greater investment in policies and programs to promote health equity. The report highlights the fact that for far too long we have been reading and hearing epidemiological descriptions of the social disparities in health, and that it is time to shift our focus to actions that can be taken to address those disparities that are most amenable to change.

Actions to promote health equity warrant the full attention of the health promotion field right now; translating our rhetoric into concrete responses. However, the Commission's report had a global scope, with an emphasis on international and national policies, so it is likely to have limited value as a source of specific direction for the majority of health promoters, especially those at the local and regional levels.

So how can we move forward? There are three central areas that deserve attention: debating and clarifying our values, building an evidence base to translate global and national research into local actions, and developing partnerships for advocacy.

Health promotion is both a moral and political project, and is fundamentally values-based. Familiar health promotion values include equity, social justice, empowerment, respect for culture and truth telling. A social determinants of health approach mandates that the 'values and ethics' perspective occupy the forefront of our thinking. Indeed, it is an ethical perspective which provides the foundation for the *Closing the Gap in a Generation* Report. To quote from the report: "Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair… Putting right these inequities – the huge and remediable differences in health between and within countries – is a matter of social justice."

The value base of health promotion sets our directions and describes the world that we want to be a part of building. The Eberhard Wenzel Memorial Oration given by Professor Fran Baum at the 17th National Conference of the Australian Health Promotion Association Conference in 2007 (see p174-178 for an abridged version), reflects these values by depicting what we could strive towards in Australia by 2040. Here, we see a focus on population health and well being as an indicator of societal progress, environmental sustainability (instead of growth at all costs) and redressing the inequity experienced by the most disadvantaged groups.

There is an implicit assumption among the health promotion movement that we have agreement on values ('we're all on the same side'). However, the discipline bases represented in health promotion today are many and varied, with subtly different definitions of health promotion evidence (truth). There is often a tension between the ethical ('what should be done') and the technical ('what can be done'). These tensions need to be made explicit to enable debate so that the priorities of health promotion are not narrowed merely to those things that can be readily achieved and measured in the short-term, but embrace the long-term social change agenda that is required to address disparities in health.

Having clarified our values, evidence is needed about what works to reduce health inequities in what circumstances, and how best to implement interventions so that they contribute to a reduction of these inequities. The evidence is strong that health and social inequities are actively produced and maintained by social, economic, environmental and political conditions.[2-3] While health promotion as a discipline might express understandings of social inequality and its role in health status, it struggles with what to do about the unequal distribution of health and its social basis.[4]

The recent arguments by Professor John Lynch,[5] that focusing on traditional risk factors may be more beneficial for reducing absolute differences in coronary heart disease (CHD) between socio-economic groups than addressing psychosocial causes, has generated interest and some consternation in the field. Lynch's conclusion is based on population data which indicate that, although differences in CHD incidence according to level of educational attainment are not explained by traditional risk factors and are probably due to psychosocial causes, the total burden of CHD experienced by the least

educated can be attributed primarily to individual factors like smoking, cholesterol etc. This proposition deserves a fuller interrogation than is possible here, and at least one response from practitioners might be that risk factors cannot be decoupled from their psychosocial causes, or their physical and cultural contexts.

We should also be mindful of the problems associated with addressing (whether in measurement or interventions) single risk factors in the absence of the spectrum of relevant risk factors for any condition. This is a central message of the social determinants of health approach. The value in Lynch's argument is that it stimulates debate and demands the collection of evidence about approaches to reducing health disparities, not just from epidemiological modelling, but the evaluation of real world strategies.

It needs to be recognised that the work of health promotion practitioners is increasingly concerned with establishing partnerships, building capacity and changing the way that systems operate to increase access to the resources needed for health. Unfortunately, the research and evaluation that is carried out in health promotion does not reflect this focus and tends to be concentrated on mid-stream and down-stream strategies with a disease or narrow risk factor orientation. There is scope for collection of a far wider range of evidence related to models of cross sectoral working, organisational change, and policy that will inform sustainable efforts to reduce health disparities.

Achieving progress in addressing health disparities will ultimately require that health promotion embraces a social change agenda. This is reflected in the way that the WHO Commission on the Social Determinants of Health described its purpose, namely "… to marshal the evidence on what can be done to promote health equity and *to foster a global movement to achieve it*" (our emphasis). The field needs to reflect on the extent to which it is organised as an advocacy body for the modification of policy, legislation, norms and values to promote healthier structural environments.

References

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