

# Reducing health inequities requires a new national health research agenda

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*"Evidence-based policy making on the social determinants of health offers the best hope for tackling health inequities. This requires good data on the extent of the problem, up-to-date evidence on the determinants and on what works to modify them in order to reduce health inequities. It also requires an understanding of the evidence among policy makers and practitioners, such that social determinants of health are acted on."*<sup>1</sup>

The Commission on Social Determinants of Health (CSDH) reported in August 2008 and held out the vision of a more equitable world. The Commission understood that this would be achieved by understanding the magnitude of inequities, and through careful inquiry into what works in different contexts around the world to determine how action for equity could be improved. In Australia, while we do describe our health inequities, what we don't do so well is understand the evidence on social determinants and how action on them offers the best hope of promoting population health equitably. Without this understanding, we are unlikely to spawn a generation of research on social determinants that really comes to grips with the complexity of action to improve health and well-being in an equitable way.

Starting points are important. It was disappointing that the National Preventative Health Taskforce<sup>2</sup> was given a brief that focused on proximal causes of disease – tobacco, alcohol and overweight – rather than one that required consideration of the underlying causes of ill-health and the conditions in which well-being flourishes. Elsewhere<sup>3</sup> I have argued that to be serious about health promotion we have to do more than deal with the tip of the iceberg, but rather explore under the surface to look at the drivers of health inequity such as gender, power, poverty and wealth distribution and taxation policy. It was pleasing to see that, despite limited terms of reference, the Taskforce did consider some structural factors that drive patterns of disease (for instance their call to regulate alcohol advertising and to use taxation to encourage healthy food supply). Yet inevitably the focus on proximal causes of disease so often leads us up the behavioural path. There is a beguiling simplicity to behaviouralism – poor behaviours lead to risk factors and disease so we should intervene with individuals to put a stop to those behaviours. Yet life is more complex than

this. Our behaviours reflect all those factors below the waterline – including our class, our gender, where we live, the jobs we do, whether we are or are not parents, whether we have robust or fragile mental health, whether we are well-connected socially and how much power and influence we have. All those factors are connected and interact. From this complexity comes health and well-being, risk factors and disease.

The CSDH's report<sup>4</sup> hardly mentions behaviour. It focuses on the conditions of daily life at work, at home, in childhood and neighbourhoods. These are framed as being powerfully affected by the distribution of power, money and resources. The CSDH report provides a strong body of evidence for the need to take a look at how health is created and how society can be structured to maximise this creation. The crucial question posed by the CSDH report is what type of research agenda is required to advance health equity in a generation?

In Australia, answering this question has profound implications for the way we spend the resources we devote to research. Currently, most funding is devoted to medical research that helps us once we are sick. By comparison, very little research resource is spent on considering what keeps us healthy, or on understanding how our public funding is best invested to improve health outcomes equitably.

We need more research that does both these things. I hesitate to use the term 'intervention research' as it implies a passivity and top-down approach that is not compatible with health promotion's dictums of advocate, mediate, enable and ensure participation. Catford<sup>5</sup> has talked of a "science of delivery" and I would like to extend this term to the "art and science of delivery". As contributions in this issue of the Journal testify, we can never capture the complex, interacting society we live, work and play in to the extent that our biomedical colleagues can capture impacts on the human body in laboratory research. Wise et al.<sup>6</sup> remind us of the potential usefulness of Health Impact Assessments. These would help to understand our social complexity through a negotiated process where knowledge and evidence are considered in a politically savvy framework. Matheson and Dew<sup>7</sup> demonstrate the value of embracing complexity (instead of trying to control for it or screen it out) and using it to take a whole system perspective and to understand social processes that underpin all our efforts to reduce health equity.

For the future, I would like to see a well-funded research agenda that grows out of a government commitment to understanding and acting on the social determinants of health. This would see reflective research that aims at understanding how policies and programs support or detract from health and well-being and how they might be made more supportive. It would have a special focus on Indigenous health and well-being. It would be designed to understand and interpret policies and programs within their complex social and political settings. It would be conducted in partnership with policy makers, practitioners and community members and produce findings useful to improving

policies and practices so that they are more supportive of health. This research agenda would be based on the premise that while health and health equity may not be the aim of all policy, they will be a fundamental result. It would focus on the health equity impact and potential of policy areas such as education, primary health care, urban planning, employment and climate change mitigation. Such an agenda is essential if we are serious about being both a healthy and equitable country.

## References

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## Towards equity as core business for policy makers and practitioners

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To achieve health equity means that we must be concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible.<sup>1</sup> Jones,<sup>2</sup> points to the need to address the social determinants of health and the social determinants of equity. Each requires different actions on the part of the health sector in particular, and on the part of government, civil society and the private sector in general.<sup>2</sup>

There are multiple reasons to be concerned about and committed to eliminating inequities in health and in the

distribution of its determinants. Ultimately, however, "the true measure of a nation's standing is how well it attends to its children – their health and safety, their material security, their education and socialisation, and their sense of being loved, valued, and included in the families and societies in which they are born".<sup>3</sup> The WHO Commission on the Social Determinants of Health<sup>4</sup> was a compelling reminder of this and of the consequences if we fail.

This issue of the Journal represents the emerging efforts to engage in the urgent, complex work that is (and will be) required to achieve health equity in Australia (and globally). It is encouraging that the papers reflect a shift in the focus of some practitioners, researchers, and policy makers within the health sector (principally) from describing the problem and analysing the determinants, to focusing on actions that need to be taken. However, the health sector, as a system, has not yet responded fully to the challenges of closing the gap and of creating equal opportunities for health. Although it is clear that the health sector cannot achieve health or social equity on its own, its leadership is vital, as is its commitment to action within its own mandate.

## Acting to achieve health equity: an agenda for the health sector

There are clear actions that the health sector can take to exercise stronger leadership in efforts to reduce social differences in opportunities for health.

### 1. Lead and contribute to action to bring health differentials down to the lowest level possible

Although there are some signs of greater commitment by governments and the health sector to achieving health and social equity, this needs to be reflected explicitly in organisational goals and strategies. The health sector has a clear mandate to provide health care (primary, secondary and tertiary) to all citizens. A priority for action to achieve health equity is to assess the current distribution and accessibility (including cultural and economic accessibility) of health services, including health promotion, and to take steps to ensure that they are:

- equally accessible for equal need;
- equally utilised for equal need; and
- of equal quality for all.<sup>5</sup>

### 2. Lead and contribute to action to create equal opportunities for health by focusing within the sector

The health sector's contribution to achieving health equity is interpreted, commonly, as being primarily closing the gap in the distribution and provision of high-quality health care services. However, the health sector as an organisation or system, actively distributes opportunities for social and economic equity in communities and society. The ways it does this include: who it selects as members of the bodies that decide on priorities and the allocation of resources within