GUEST EDITORIAL

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Sometimes it can be difficult to ground, in easily understandable facts and ideas, the often detailed and complex statistics and theories about health inequalities. Some eyes glaze over when the 10-year changes in standardised mortality ratios in the first and tenth equivalised family income deciles are discussed. What, however, could be easier to understand, or closer to home, than the results of McCracken’s statistical modelling, which suggests that in NSW each year almost 5000 premature deaths might be prevented if we could remove all inequality in our society. Put another way, if all of the people of NSW enjoyed health similar to that enjoyed by the people of Northern Sydney then one in four deaths would be avoided—and one in two of the deaths in the Far West would be avoided.

Such stark conclusions stimulate consideration of why inequalities exist, and the other four contributions in this issue take up the challenge of understanding the reasons. Awofeso and Eckersley discuss predominantly global matters. Picking up Stilwell’s arguments from an earlier Bulletin (Volume 12, Number 7), Awofeso highlights some of the ways in which globalisation has detrimental effects on health, particularly poor people’s health, in poorer, internationally less powerful, countries. He calls for a new agenda involving intersectoral collaboration, engagement with civil society, responses to local concerns, and respect for human rights.

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Eckersley argues that, in developed nations, economic growth is no longer associated with improved social wellbeing (for instance, life satisfaction and happiness); people are concerned about unfettered materialism and individualism, and the pressures these place on individuals, and they want more balanced lives. Eckersley questions the commonly-held assumptions about growth that inform decision making and calls for a better balance between a ‘wealth producing economy’ and a ‘health producing society’. The need for both, not one or the other, has also recently been voiced by Deaton who argues that ‘individual welfare is neither health nor wealth but depends on both’.2 Deaton, an economist, is critical of those in the public health community whose policy proposals ‘emphasise health without adequate attention to the other aspects of wellbeing’.

Quiggin focuses our attention on changes in Australia over the last two or three decades: on the shift in the economy and employment patterns from primary production and manufacturing to personal and community services; and on the negative effects of microeconomic reform on publicly-financed human services, the emphasis on market forces, and ‘managerialism’. Quiggin emphasises the well-established links between education and health, in developed as well as developing countries, and laments the cuts in Australian public expenditure for education and the consequences of these for children from low-income families.

Webster is critical of top-down ‘tweak the knobs on the grand dial’ approaches to health improvement, because they do not take account of the diversity within and between communities or the need for individuals and communities to use their own skills and resources to build resilience rather than just avoid disease. To be successful, Webster argues, public health programs must use community development and partnerships, and must focus on socially-excluded groups.

Global forces, national policies, local priorities, personal behaviours. How do we make any coherent sense of the many factors that influence health inequalities? (And the articles featured in this issue of the Bulletin focus on just a few.) It is important that we develop and make explicit our understanding of how inequalities arise, because our explanatory theories determine our preferred approaches to solutions. Those who believe that unhealthy lifestyles, arising from ignorance or wilful neglect, create inequalities in health will focus their action around behaviour change by, for instance, education, persuasion and legislation. Those who believe that health inequalities are caused by an inability to afford the basic essentials (for instance, nutritious food, safe shelter, and basic health care) may favour welfare programs and safety nets. Those who believe that the existence of a social hierarchy creates health inequalities probably favour measures that will produce social and cultural change, possibly involving the redistribution of wealth and greater democracy.

On the evidence currently available, we believe that there are multiple causes of health inequalities; that the causes vary from place to place and over time; and that, whoever and wherever you are, global, national, local, and personal influences all play a part. Many authors have developed diagrammatic models to represent this complexity in a reasonably simple form.3,4 One of the more comprehensive models identifies three interacting levels of factors: upstream (global forces and government policies); midstream (psychosocial factors, health behaviours and the health care system); and downstream (physiological systems and biological reactions).5

Acceptance of such a broad ranging explanatory framework requires that action be taken at all of these levels to reduce inequalities. At the global, national, and local levels, we must ask: ‘What sort of society do we want to live in?’ We are all conscious of the difficulties involved in changing societies—for instance, vested interests, unequal power relationships, differing value systems, resource constraints and historical legacies—but most of us do not want to live in a world characterised by violence, dishonesty, environmental destruction, prejudice, and inequity. At the personal level, we must ask: ‘What can I do to improve my own and my family’s health?’; ‘How do I want to relate to my family, friends and neighbours?’; and ‘What contribution can I make to creating the sort of society I want to live in?’

But what can we do as public health professionals to reduce inequalities? Wise recently offered some suggestions about how to become active in our personal lives and through our professional associations and work places.6 We must, however, see the whole, not just the parts, in both the sites of action and the actors. We must find ways to change the upstream global and national influences on personal and population health while at the same time working with individuals and communities to alter midstream and downstream factors that directly affect our lives. We must also recognise and act with others who promote greater equity—for instance, the environmental movement, progressive movements in education, social welfare and employment, and human rights organisations. Understanding the pathways through which inequalities are created and maintained is, however, an essential prerequisite.
WHAT IF NEW SOUTH WALES WAS MORE EQUAL?

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In the international health status ‘league tables’, Australia ranks among the best in the world. For example, on the measure of healthy life expectancy (that is, disability-adjusted life expectancy), the World Health Report 2000 rated Australia second out of 191 countries. However, as Sainsbury and Harris remind us in the guest editorial to the first issue in the health inequalities series of the NSW Public Health Bulletin (Volume 12, Number 5): ‘there are substantial inequalities in health in NSW and Australia’ and ‘these inequalities translate into large differences in levels of mortality and morbidity’.

This article describes an estimate of the excess mortality burden in NSW and focuses on the following questions: What if NSW was more equal? Each year, how many premature deaths might be prevented if we could remove all inequalities in our society?

Clearly, there is no unequivocal or precise answer to these two questions, as the answer depends on how ‘excess’ mortality is identified and measured. Despite the elusiveness of any definitive answer, the questions are worth posing because they remind us of the scope that still remains for reducing premature mortality across New South Wales.

BACKGROUND—APPROACHES TO MEASURING EXCESS MORTALITY

The notion of excess (or avoidable, unnecessary, and preventable) mortality has a lengthy history, dating back at least to the mid-nineteenth century in the work of the English statistician, William Farr. Concerted research interest in the topic, however, is more recent, developing over the past three decades or so.

Two basic types of methodologies have been employed to estimate excess mortality. The first type of methodology has been based on identifying causes of death that supposedly can be prevented in various ways. Work in this methodology derives from a compilation of a list of ‘unnecessary untimely deaths’ (that is, ‘sentinel health events’) by a working group on preventable and manageable diseases in the United States. Subsequent researchers have used and extended this list in studies of avoidable mortality in a wide variety of geographic settings. Early work in this methodology tended to focus on mortality from conditions amenable to medical intervention (that is, secondary and tertiary prevention), but some of the more recent studies have extended the concept of avoidability to cover primary prevention (that is, reducing the incidence of the condition through individual behavioural change and population level interventions).

The second type of methodology has been based on the idea of selecting a favourable level of mortality as a standard and then defining excess deaths as those above that reference level. This, in fact, was the approach taken by Farr in the nineteenth century. Farr noted that, in districts in England with the most favourable sanitary conditions, the crude death rate did not exceed 17 per 1000 population; and, accordingly, he adopted this rate as representing ‘natural’ deaths. Any deaths above this rate were deemed to be ‘unnatural’. Several variants of this ‘best mortality’ criterion have been used by modern researchers. One strategy has been to use the age-specific and sex-specific mortality prevailing in the highest social class as a benchmark. Another has been to assemble the lowest age-specific and sex-specific death rates recorded in selected geographic units as a benchmark.

An interesting recent British study, meanwhile, has placed

REFERENCES