

Social determinants and the health of Indigenous Australians

Michael Marmot

Health is dependent on conditions that enable people to live lives they would choose to live

Inequalities in health arise from inequalities in society. Small differences in society result in small health inequalities; large differences result in large health inequalities.¹ Differences in access to health care matter, as do differences in lifestyle, but the key determinants of social inequalities in health lie in the circumstances in which people are born, grow, live, work, and age. These, in turn, arise from differential access to power and resources. Such was the conclusion of the World Health Organization Commission on Social Determinants of Health (CSDH).² The CSDH had an optimistic tone. Reviewing evidence from around the world, and reaching judgements on what works, it concluded that it is indeed possible to make great progress in closing health gaps — in a generation.

The much-discussed 17-year gap in life expectancy between Indigenous and non-Indigenous Australians bespeaks large social inequalities.³ One can think of two classes of influence to which the remarkably poor health of Australian Aboriginals and Torres Strait Islanders can be ascribed. The first is social disadvantage and the second (common to other Indigenous groups) is the particular relationship of Indigenous Australians to mainstream society.

Considering the first class of influence — social disadvantage — the health situation of Indigenous Australians fits with findings from other parts of the world. However, it is necessary to take a more comprehensive approach to social disadvantage than simply attributing it to “poverty”. For example, following the publication of the CSDH Report,² I was asked by the British government to investigate how the CSDH findings could be applied in one high-income country — England — and the resulting Marmot Review was published as *Fair society, healthy lives*.⁴ We made recommendations in six domains, all of which I suggest apply to the health situation of Indigenous Australians. These domains are:

- early child development;
- education and skills development;
- employment and working conditions;
- minimum income for healthy living;
- sustainable communities; and
- a social-determinants approach to prevention.

In both the CSDH Report² and the English review,⁴ we emphasised the social gradient in health: the lower the social position the worse the health. It might be argued that the subtlety of the social gradient does not apply to the dramatic health disadvantage of Aboriginals and Torres Strait Islanders. I disagree for two reasons. First, in any gradient there will always be people at the most disadvantaged end. Deprivation in relation to the six domains in *Fair society, healthy lives*⁴ may be extreme, but these six domains are likely to apply. For example, Coleman and colleagues in this issue of the Journal (page 535) report that a high proportion of the urban Indigenous Australian children for whom child health checks were performed came from households with unemployed parents, single parents, and a history of domestic violence.⁵ Evidence suggests that the environment in early childhood is key to health status right along the social gradient.^{2,4} This situation is not so very

different in kind from disadvantage found, to varying degrees, elsewhere.

The second way in which the social gradient is relevant is that it shows we are not dealing with poverty in the sense of the destitution seen in the poorest countries. Striking among the causes of premature mortality among Indigenous Australians are the high rates of cardiovascular disease, diabetes, kidney disease and cancer — diseases that are closely linked to social causes, which are not well understood by simply grouping them as “poverty”.⁶ Having the minimum income necessary for a healthy life is, of course, important, but it was only one of six recommendations in the Marmot Review. Action has to be taken on the other five, listed above, at the same time. Early child development, access to education, and then, with the requisite skills, access to jobs will all be important. Note that this approach does not ignore the high rates of drinking and smoking among Indigenous Australians. I have borrowed the phrase “the causes of the causes”.⁷ It is a reasonable hypothesis that, given good early child development, education, and access to decent work, high rates of smoking and alcohol misuse will be less of a problem.

It is difficult to make fundamental changes, but change is possible and it can happen rapidly. Taking the example of educational opportunities, for instance, it took more than 110 years from the establishment of the first Australian university in 1850 until the first Australian Aboriginal, Charles Perkins, graduated in 1966.⁸ However, less than 30 years later (in 1991), it was estimated that there were more than 3600 Indigenous Australian graduates, and this number had increased to over 20 000 in 2006.⁹

The second of the classes of influence that help explain the poor health of Indigenous Australians is their marginal position in relation to mainstream society. A fundamental theme of both the CSDH Report² and the English review⁴ was the importance of creating the conditions that enable people to take control of their lives. If people were living lives they valued, either in remote rural areas or on the margins of cities, that would be one thing, but if Indigenous Australians do not have the conditions — the six domains — that would allow them to live lives that they would choose to live, ill health is an inevitable result. The challenge now is to apply the findings from research on the social determinants of health that would enable Indigenous Australians to lead more flourishing lives that they would have reason to value.¹⁰

Author details

Michael Marmot, PhD, FRCP, FFFHM, FBA Professor of Epidemiology and Public Health,¹ and Chair (2005–2008), Commission on Social Determinants of Health (World Health Organization)

1 University College London, London, UK.

Correspondence: m.marmot@ucl.ac.uk

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