TOPIC 2
What influences the health of individuals?

OVERVIEW
2.1 The determinants of health
2.2 The degree of control individuals can exert over their health
2.3 Health as a social construct
2.4 Topic review

OUTCOMES
In this topic students will:
- describe how an individual’s health is determined by a range of factors (P3)
- evaluate aspects of health over which individuals can exert some control (P4)
- use a range of sources to draw conclusions about health and physical activity concepts. (P16)
Our ability to achieve and maintain good health is influenced by more than just the decisions we make about particular health behaviours and the lifestyle that we choose to lead. The differences between the health status of various groups of young people we learned about in topic 1 highlight that our health is influenced and determined by a range of factors. These factors, or determinants as they are commonly called, include factors relating to culture, the societies in which we live, economics and environmental conditions, along with factors relating to the individual. These factors rarely impact on individuals and communities in isolation. Rather, they are often linked, meaning that a range of determinants interact to have a positive or negative impact on health. A number of these determinants are outside the control of the individual, making it harder for people from particular groups within Australian society to exercise a high degree of control over their health and easily make changes to bring about improvements.

In this topic we learn about the various determinants of health in order to understand how they work together to influence the health and well-being of people. We also look at the degree to which these determinants can be modified to assess how much control individuals are likely to have over their health, both now and in the future. This assessment allows us to investigate differences between the health of particular individuals and population groups in Australia and explore reasons for these inequities.

2.1 The determinants of health

It is now widely accepted that a person’s health is determined by more than just genetics and the lifestyle choices that each person makes. Research has shown that the health of individuals and communities is affected by a broad range of factors relating to the community, environment and social context in which people live and work, along with the health behaviours that individuals adopt. The factors recognised as major influences on our health and well-being are generally referred to as determinants of health. Health determinants are defined as those factors that positively or negatively affect the health of individuals or communities, or put more simply, things that make people healthy or not. The key determinants of health are:

- individual factors, such as knowledge, skills, attitudes and genetics
- sociocultural factors; for example, family, peers, media, religion, culture
- socioeconomic factors, including employment, education and income
- environmental factors; for example, geographical location, access to health services and technology.

While each of these factors is going to be discussed individually in the following section, it is important to understand that they do not impact on people’s health as isolated factors. Rather each determinant can be expected to have an influence on another. For example, living in an area with a high level of air pollution (environmental factor) is likely to be linked to a person’s income (socioeconomic factor). Our health status is therefore the result of a complex interaction between the various health determinants.
2.1.1 Individual factors

Individual factors are those factors unique to each person that can determine their level of health. They include:

- the knowledge we have about health and the skills we possess that enable us to act in ways to promote better health
- the attitudes and values that we place on health and the importance of leading a healthy lifestyle
- genetic factors that increase the likelihood we may experience particular health problems.

Knowledge and skills

The knowledge and understandings that we develop about protective and risk health behaviours, and about products and people available to support good health have an important influence on our ability to act in ways that contribute to good health. When we compare the health of people with differing levels of education we find that those with lower levels of education are at greater risk of poor health, have higher rates of serious chronic health conditions and illness, and live shorter lives than those with higher levels of education. They are also more likely to perceive their health as fair or poor.

Our knowledge about health comes from a variety of sources — parents, siblings, peers, teachers, the internet and the media all play a part in conveying information about health. Previous experience can also contribute to what we know and understand about particular health problems. Having knowledge does not mean that people are able or willing to make healthy choices. However, good health literacy will enable people to better access, understand and use information in ways that can promote or maintain good health. It also helps them to assess the accuracy and reliability of information they may find.

SNAPSHOT

Lack of sexual health education leads to unsafe behaviour

By Chloe Papas

Young people are the biggest contributors to increased rates of sexually transmitted infections across Western Australia.

A report recently published by the WA Health Department shows a significant spike in the number of sexually transmitted infection cases reported by young people in the state, and has led to calls for improved sex education.

The report highlights the notification rates of gonorrhoea in particular, with 54 per cent of cases reported by 15–24-year-olds.

A statement released by the department earlier this week illustrated that gonorrhoea reports doubled between 2011 and 2012 for the same age group.

Though high reporting rates are positive because more people are getting tested, the prevalence of sexually transmitted infections in the 15–24-year-old age group has led to questions about attitudes towards safe sex.
Youth Affairs Council of Western Australia CEO Craig Comrie says the issue comes down to a lack of education.

‘For a long time, sexual health has remained this taboo issue, people are petrified of talking to young people about it.

‘But the reality is, particularly with the concerning stats that are coming out from the department, if we don’t start to have an open discussion with young people about this issue, we’re just going to see the problem worsen.

‘We’re just not talking to young people about sexual health and healthy relationships.

‘We really don’t put prominence on young people’s sexual health as opposed to other health aspects on their life — we put a lot of focus on physical health and well-being, a lot of focus on their mental health, but unfortunately we ignore sexual health.’

Family Planning Western Australia (FPWA) spokesperson Rebecca Smith says there are a number of reasons why young people might engage in unsafe sexual behaviour.

‘There’s a peer pressure factor, drugs and alcohol are often involved which leads to their inability to make safe decisions.

‘Lack of education, lack of knowledge about contraception, lack of knowledge about STIs and pregnancy — it can be a really varied combination.’

School-based education

Schools in Western Australia can choose whether to teach sexual education as part of their curriculum, and can also decide the extent to which it is implemented.

‘Some schools have a very comprehensive sexual health education program, and young people are getting lots of sexual health knowledge, whereas some schools have none, so people are coming away with very little,’ says Smith.

Though there is a national curriculum in place for sexual health education, there is no obligation for schools to implement it.

Organisations like FPWA offer sexual education training to schools and teachers across the state, but services are only taken up by those who request them.

The willingness of private religious schools to teach sexual education is another contributing factor to the extent of education across the state.

‘We know that the majority of religious schools do absolutely no sexual health education and the ones that do, often it’s a very clinical focus,’ says Comrie.

‘Though that [clinical] information is important, it isn’t enough to equip young people with the information required to allow them to make positive decisions about their sexual health and behaviour.’

Other practitioners within the health and education sectors, including youth workers, counsellors and nurses, are generally not trained in youth sexual health and sexuality while at university or TAFE.

Comrie confirms that YACWA have partnered with one TAFE in WA to educate future youth workers in youth sexual issues.

Misconceptions

According to both Comrie and Smith, research shows that young people are highly likely to access information about sex through their peers.

Smith says that there are a number of common misconceptions that young people cite when accessing services through FPWA, including the belief that STIs cannot be contracted through oral sex, and that if a woman is taking birth control pills she is also protected against any sexually transmitted infections.

Judgemental and negative attitudes among adults can easily lead to a lack of positive education and communication, says Comrie.

‘There’s this attitude that if you talk to young people about sex early, then they’re going to want to run out and go and have sex.

‘But the evidence suggests that the complete opposite is the case, that if you actually empower young people and educate them, they’re more likely to delay their first sexual experience.’

Sexual health campaigns through organisations and the health department often encourage young people to ‘have the conversation’ with partners — and Comrie says that the same message can be applied to education.

Inquiry
Developing knowledge and skills to improve health

Read the snapshot ‘Lack of sexual health education leads to unsafe behaviour’ and then complete the following.
1. What reasons are put forward in the article for the lack of education young people receive about sexual health?
2. How are knowledge and skills likely to empower young people to make positive decisions around sexual health?
3. Explain how the attitudes and judgements of adults can negatively affect young people’s ability to access and gain accurate, reliable knowledge about sexual health.
4. Propose two strategies that would help strengthen young people’s sexual health knowledge and skills.

The acquisition of skills related to decision making, problem solving, communicating, interacting and moving may also contribute to improved health. For example, having a wide range of movement skills provides people with the confidence to participate in sport and physical activity and try new things. Similarly, being able to effectively negotiate with others and resolve conflict can help maintain positive relationships. As with knowledge, having these skills does not ensure that people will always act in healthy ways. However, it does empower people and makes it easier for healthier choices to be made.

Attitudes

There is a strong link between knowledge and attitudes, with a person’s level of knowledge likely to influence the attitudes they develop and the way they behave. For example, someone who has respectful attitudes towards women is less likely to be violent or excuse disrespectful and aggressive behaviour towards girls and women, and more likely to have positive, healthy relationships. The attitudes we hold are influenced by families, peers, education, the media, our culture and the communities in which we live. Our sense of self-efficacy also has an influence on our attitudes and whether we feel capable of making lifestyle changes that may improve our health.

People’s attitudes towards certain health behaviours, their willingness to seek help to address health concerns and the value they place on positive health all play a part in determining someone’s health. Research into the factors that affect young people’s willingness to seek help for mental health issues has identified a number of key barriers to accessing help. These include feelings of embarrassment, a preference for managing problems without help, and concerns about opening up to people they do not know (for example, counsellors) who are potential sources of help. On the other hand, those who held positive attitudes towards health professionals are more likely to seek help. Knowledge about the type of help available and where this help could be found also served to encourage help-seeking behaviour.
### Inquiry

**Young people’s attitudes towards health**

1. Consider the attitudes young people may have in relation to one of the following health behaviours:
   - (a) pressuring a partner into being sexually active
   - (b) using a mobile phone while driving
   - (c) seeking professional help to cope with personal problems
   - (d) posting sexually explicit images online.
   - (e) drinking energy drinks on a daily basis.

2. Discuss the possible immediate and/or long-term health outcomes of different attitudes regarding the chosen health behaviour.

3. Outline factors that may influence the attitudes young people develop around this health behaviour.

---

Changing circumstances, such as parental separation, or living through particular experiences (for example, a car crash) may also see our attitudes change, leading to corresponding changes in the way we behave.

![Figure 2.4](https://example.com/figure2.4.png)

**Figure 2.4** Attitudes towards seeking professional help can affect a person’s level of health.

**Source:** © headspace.

### Genetics

Our potential to achieve a certain level of health may be significantly influenced by genetics. A number of genetic disorders, such as muscular dystrophy and cystic fibrosis, lead to chronic ill health and decreased life expectancy. These diseases are caused by genetic information passed on by parents at conception. Other disorders such as Down syndrome, which can affect physical development and intellectual functioning, are the result of chromosomal abnormalities that occur during pregnancy.

Genetics can also play an important role in a person’s susceptibility to certain diseases or health problems. People with fair coloured skin, which is a genetically inherited trait, are at greater risk of developing skin cancer as their skin burns more easily and more quickly following exposure to the sun. Research has identified that diseases such as breast cancer, asthma, heart disease, diabetes and some mental illnesses have a genetic link, making those with a family history of these diseases more susceptible to developing the disease themselves.
The genetic information that we inherit can also positively influence our health as it can provide us with potential in terms of intellectual capacity, physical abilities and life expectancy. For example, hereditary factors have an effect on how fast we can run, how coordinated we are and how well suited we are for particular sports. Hereditary factors therefore have an influence on our sporting abilities and likelihood of successful participation.

However, while genetics influence our health potential, there is no degree of certainty that we will inherit all of the health conditions of our parents or grandparents. Many genetic disorders are complex and do not follow a clear-cut pattern of inheritance. Lifestyle and environment also play a part, meaning that if people make positive adjustments to how they live they can reduce their risk of ill health and maximise their potential. Similarly, even though we may have inherited superior genes for both physical and intellectual growth and development, a poor physical and sociocultural environment can negatively affect our level of health. This reduces our potential.

2.1.2 Sociocultural factors

The communities in which we live and the groups to which we belong all have a significant influence on the values, attitudes and behaviours we adopt in relation to our health. These are referred to as sociocultural factors.

Our families, peer group, the media, religion and cultural background are the sociocultural factors that exert the biggest influence on our level of health. Each of these sociocultural factors plays a significant role in shaping our values, determining our knowledge and influencing our health behaviours through the expectations they create, the health behaviours they encourage and the cultural practices they support. Assumptions relating to how certain groups should look, think and behave (for example, males and females) can contribute to expectations of conformity that leads to risk taking. Those who are unwilling or unable to meet these expectations can feel a sense of alienation that is detrimental to well-being.
Family

Research has shown that a person’s family and their home environment can significantly influence their health and well-being. Families are responsible for ensuring physical needs such as safe housing, food, clothing and medical requirements are met while also providing emotional support such as love and care. Research has shown that how a family functions is critical to the health and well-being of its members. Being part of a cohesive family acts to protect the health of children and young people, and helps them cope better when they experience stressors or tough times in their life. Children living in situations of violence, abuse or neglect are at risk of immediate physical injury and emotional distress and are likely to suffer adverse consequences on their long-term physical, emotional and social well-being.

Families play an important part in promoting good health and positively influencing members of the family to behave in ways that protect their health. For example, when, what and how much food is served and eaten are all behaviours that develop within the family unit. Families that serve three daily meals containing a wide variety of nutritious foods in the appropriate amounts not only ensure that nutritional requirements for healthy growth and development are met, but also instil in children the importance of healthy eating. Family expectations about the type of behaviour that is appropriate and acceptable are also an important factor. Research has found that children living in households where someone smokes are more likely to take up smoking themselves, particularly when their smoking is condoned or accepted by their parents.

Families are also an important source of information and support when people experience health-related problems. In addition to providing someone to talk to and seek advice from, families can also facilitate access to medical professionals and health services. Research indicates that people who lack social support from their family have higher rates of illness and death than those who are able to use their families as a source of knowledge and assistance.

SNAPSHOT

Why kids are inactive (and why it’s not just their parents’ fault)

By Cassie White

Australia is famous for its active outdoor lifestyle. So it might come as a surprise to find out the vast majority of children are not spending enough time being active.

Despite having top-notch parklands, facilities, sporting fields and cycle-ways, not even one in five Australian kids aged between five and 17 get anywhere near the recommended 60 minutes of physical activity a day.

There are so many reasons why kids need to be physically active. It improves fitness, helps with weight maintenance, strengthens muscles and bones and reduces their risk of heart disease and type 2 diabetes later in life.

Regular physical activity has also been found to help children be more confident, have better concentration, and to be better able to cope with stress and regulate their emotions.

We often blame parents, schools, government policy and excess screen time for kids’ sedentary lifestyles. The latest report card on physical activity suggests each of these plays a role.

But Dr Natasha Schranz says our tendency to over-schedule children’s time is part of the problem.

Dr Schranz, the report card’s lead investigator, understands parents are keen to give their children as many opportunities as possible — dance classes, piano lessons or chess club. But this often means less free time to just play outside.
As a parent of two young girls, Dr Schranz appreciates the tension.

‘But I’m mindful of the time I do schedule for them versus the time where we just walk the dog or head to the playground. The things that should just happen in everyday life.’

She points out that even when children take part in organised sports — such as cricket, soccer, hockey or netball — a lot of that time isn’t actually spent being active. They spend a lot of time taking instruction or waiting their turn.

Also the activities they do in school and club sports are not always enough to ensure they develop the motor skills and movement patterns that are the building blocks of other movements. Without these patterns — running, jumping, leaping, galloping, skipping, catching, throwing and kicking — it makes it hard to build confidence with a whole range of physical activities.

‘This is why we need to give kids time for unstructured rough and tumble play without rules, boundaries and scheduling by adults,’ she says.

‘It needs to be about them wanting to explore and try new things, rather than physical activity being something you have to schedule in.’

**Time isn’t on our side**

But trying to work this free play into family life is not always that simple — as many busy parents would argue.

Magdalena Wahhab is a working mum with a six-year-old daughter. She’s an avid gym-goer and organises as much for her daughter as she can, on top of school commitments.

But there are only so many hours in a day.

‘Parents work such long hours; it’s hard to accommodate all the kids’ needs on top of cooking dinner and helping with homework,’ she explains.

‘My daughter does a few activities during the week, then we squeeze in as much as possible on weekends. ‘But there just isn’t enough time for all the fun, enjoyable things like playing with friends during the week.’

Plus, when you finally get ten minutes to yourself at night after dinner, homework, washing and preparing for the next day, ‘sometimes it’s easier to let them play on the iPad than jump on the bike’.

Dr Schranz agrees that life and parenthood is a constant juggle of priorities.

‘So in my house, we prioritise the commute to and from school,’ she says.

‘Above everything else, we walk, ride or scoot there. It’s free and something we have to do five days a week, back and forth.’

She says even if you don’t live within a few kilometres from school, there are always options: park a few kilometres away and walk, or get off public transport a few stops earlier.

**What about the bookworms?**

While team sport may be a big part of many school kids’ lives, there’s also the reality that not all children enjoy team sports. Some kids are arty, others prefer to read, and some suffer body image issues.

Oftentimes these children fall through the cracks.

That’s the case for Julie Boland’s 14-year-old daughter.

‘She was a great swimmer when she was younger, but now she’s really tall for her age and is suffering with weight issues. It has really knocked her confidence,’ she explains.

‘She’d been trying out for school championships, but was being so badly bullied by kids because of her height. ‘If you aren’t the sports star at school you don’t exist, so sometimes she’d just sit in her room.’

Without support from the school, Julie is doing everything she can to keep her teenager moving at home to build confidence and fitness.

‘She’s now doing personal training one to two times a week and I’m trying to encourage her to do classes with me in the morning,’ she said.

‘I do gardening jobs after work so I take her with me. She plays with the dogs or runs around with the babies to give the mums a break.

‘But it has taken a long time for me to get her confidence up.’

At the end of the day, it takes a village to raise a child, Dr Schranz says. She and the other authors of the report say this ‘physical inactivity pandemic’ requires a coordinated response.

‘It comes down to parents, teachers and schools to share the load in teaching kids these skills,’ she said.

*Cassie White is a Sydney-based personal trainer, yoga coach and health journalist.*

Inquiry

The influence of families on health

Read the snapshot ‘Why kids are inactive (and why it’s not just their parents’ fault)’ and complete the following.

1. Describe how parents can influence their child’s level of physical activity.
2. What factors make it hard for parents to provide their children with time to be active, particularly to have time for free play?
3. The article argues that unstructured play is important for the development of motor skills. What reasons are put forward for this argument. Do you agree?
4. Besides parents, identify the other sociocultural influences on physical activity mentioned in the article. Outline how these can also affect children’s physical activity levels.

Peers

Peers also have a powerful influence on people’s health choices and the type of behaviours they undertake. This influence may be beneficial to their level of health or can have a negative impact. Young people can be particularly influenced by the values, attitudes and behaviour of their peers as they seek to establish their identity and feel a sense of belonging. When peer groups share common interests and similar values it can be easier to make healthy choices. For example, being part of a peer group that enjoys being active and supports the participation of people regardless of their level of ability will help people feel comfortable and encourage them to join in sporting or recreational activities.

Making healthy choices can be more difficult when the peer group is not supportive or when the values held by those in the group differ from those held by the individual. For example, it can be difficult to maintain a decision not to drink alcohol if you attend a party where everyone else is drinking and you are continually offered a drink or questioned about why you are not drinking.

Inquiry

Exploring the influence of family and peers

Consider the following lifestyle behaviours that can positively or negatively affect your health:

- participating in regular physical activity
- tobacco use
- eating a healthy diet
- using sun protection
- safe driving behaviour.

Explain how your family and peers have influenced your knowledge, values and attitudes in relation to each lifestyle behaviour. Determine the group that you believe has the greatest influence on your attitudes and behaviour and justify your choice. Discuss your findings with a classmate.
Media
The powerful influence that the media can have on a person’s opinions, beliefs and habits makes it an important socio-cultural determinant of health. Electronic media such as the internet, television and movies, along with written forms of media such as newspapers and magazines, all play a significant role in disseminating information relating to health. For example, advertisements about skin cancer or stories on domestic violence seek to raise awareness and enhance people’s understanding of health-related issues. It is crucial that any health-related information presented in the media is accurate, fair and balanced, as bias or inaccuracies can lead to misconceptions and confusion that can endanger someone’s health.

The choices relating to health that individuals make are significantly influenced by values and attitudes promoted through the media. For example, research has shown that exposure to pornographic material can influence a young person’s thoughts and expectations within an intimate relationship such as what types of sexual activities they expect their partners to give or receive. Sexually explicit images can also impact on young people’s adoption of unsafe sexual health practices such as engaging in casual sex or not using condoms. These images may reinforce gender stereotypes and can strengthen attitudes that support sexual violence and violence against women.

Images conveyed through the media can also have a significant impact on what is seen as normal behaviour and risk taking that may occur as a result. Images of males driving powerful vehicles at high speed, such as in car chase scenes, or increased advertising of alcohol in the lead up to New Year’s Eve, Australia Day and major sporting events can encourage behaviours that may lead to immediate and long-term health harms and reinforce a belief that certain behaviours are acceptable and not a major concern. Similarly, the constant portrayal of images of women who are tanned, attractive and slim, and of men who are tall, tanned and muscular can contribute to beliefs about what is the ideal body shape. Pressure to conform to these stereotypes can have a considerable influence on people’s self-image, their feelings about their appearance and the health behaviours they adopt in an effort to match these expectations.

The media can also assist to shift society’s attitudes about particular health behaviours. Health promotion campaigns on television and radio, such as those about unsafe driving behaviours or binge drinking, are frequently used to not only raise awareness, but also to challenge people’s beliefs about what is acceptable behaviour in an effort to improve health and reduce rates of mortality and morbidity.
SNAPSHOT

Social media can be bad for youth mental health, but there are ways it can help

By Jo Robinson, Eleanor Bailey, Sadhbh Byrne (University of Melbourne)

Young people spend a lot of time on social media. They’re also more susceptible to peer pressure, low self-esteem and mental ill-health. A number of studies have found associations between increased social media use and depression, anxiety, sleep problems, eating concerns, and suicide risk. Certain characteristics of social media may contribute to these negative effects.

Cyberbullying

Cyberbullying has been linked to depression, anxiety, social isolation, and suicide. Compared to ‘traditional’ forms of bullying, cyberbullying can be witnessed by a larger audience, the perpetrator can remain anonymous, and the victim may find it difficult to escape.

Social media platforms have taken steps to address cyberbullying (such as Facebook’s ‘bullying prevention hub’), and almost all social media content can be reported to site administrators. But many victims don’t seek support, and research suggests 71 per cent of young people don’t think social media platforms do enough to prevent cyberbullying.

Comparisons to unrealistic portrayals

A common social media activity is viewing others people’s profiles. But these frequently portray edited versions of people’s lives, such as only displaying images in which the person looks attractive or is seen enjoying themselves.

So young people may develop an impression other people’s lives are preferable to their own.

This can be made worse by the social endorsement provided by the number of ‘likes’ a post might get. In one study, nearly one-fifth of respondents said they’d delete a post if it didn’t receive enough ‘likes’.

Suicide and self-harm content

The potential negative impact of social media on at-risk young people is receiving increasing attention. Risks identified include the potential for contagion or copycat events; sharing information about suicide methods; encouragement to engage in suicidal behaviour; and the normalisation of suicide-related behaviour as an acceptable coping mechanism.

Some benefits

There are also significant potential benefits social media can provide. It can create a sense of community, and facilitate the support from friends. It can encourage people to seek help and share information and resources. More frequent social media use has been associated with improved ability to share and understand the feelings of others.

The reach, cost-effectiveness and accessibility of social media means information, support, or treatment can reach people who might not otherwise have easy access. Clinical services are beginning to harness the benefits of social media to augment the care they provide. For example, colleagues at Orygen developed an online platform for clients and their families to augment face-to-face treatment. It has been trialled with promising results.

Monitored language used in online posts might also enable tracking and detection of people who may be at risk.

For example, Facebook recently launched ‘proactive detection’ artificial intelligence technology that will scan all posts for patterns of suicidal thoughts, and when necessary send mental health resources to the user or their friends, or contact local first-responders.

But there are ethical implications, which include privacy and duty of care. Social media’s rapidly evolving nature, reach and anonymity make rigorous evaluation of its risks and benefits challenging.

Chicken or egg?

Most studies examining social media and mental health aren’t able to determine whether spending more time on social media leads to depression or anxiety, or if depressed or anxious young people spend more time on social media.
But the way social media is used is important. For example, active (compared to passive) social media use can be beneficial. Although browsing Instagram has been associated with increased depression, talking to others online increases life satisfaction.

And some individuals may be more susceptible to the negative aspects of social media than others. Research suggests personality traits and the level of envy felt towards others online influence whether one will be negatively impacted.

The pathways to mental illness are many and varied, and to suggest mental health problems can be attributed to social media alone would be an over-simplification. But we need to acknowledge the risks and platform administrators, parents, mental health organisations, schools and universities, and young people themselves have a role to play in minimising these risks.

It’s unlikely social media use will decrease in the near future, so we need to manage the risks and harness the potential benefits to improve the mental health of our young people.

Source: The Conversation, 12 December 2017.

Inquiry

The impact of social media on health

Read the snapshot ‘Social media can be bad for youth mental health, but there are ways it can help’ and then complete the following.

1. Discuss the ways in which social media can have positive and negative influences on the mental health of young people.

2. To what extent do you agree with the ideas expressed in the article on the influence of social media?

3. What are two health issues that affect young people (besides mental health) that might be positively and/or negatively influenced by various forms of media?

4. Many people feel that social media has a more powerful influence on young people than any other form of media. Do you agree? Give reasons to support your opinion.

5. Analyse how individual factors may affect the level of influence that the media has on young people’s health. Provide examples to support your answer.

Religion

Religious beliefs are another sociocultural factor that can influence people’s health decisions and behaviours and therefore affect their level of health. Beliefs relating to food, sexual activity and drug use are examples of areas where people’s religious faith can affect their lifestyle and choices. According to some religions people should not engage in sexual activity prior to marriage, so risks associated with sexual behaviour, such as sexually transmitted infections or unplanned or unwanted pregnancies, don’t exist for those who practice these faiths. Certain religions, such as Islam, Seventh Day Adventism and Buddhism, forbid or discourage the consumption of alcohol, meaning that the risk of suffering health problems related to alcohol is reduced for people who adhere to these beliefs. Religious beliefs and practices around food can also restrict the eating of certain types of food, influence the way it is prepared, or affect eating patterns. The teachings of Seventh Day Adventists, which emphasise diet and health, require people of this faith to follow dietary restrictions that are believed to conform to Biblical guidelines. A vegetarian diet is recommended and followers are encouraged to eat wholegrain products rather than refined foods, limit fat consumption and drink large amounts of water. Adherence to these beliefs is likely to benefit physical health by reducing health risks associated with unhealthy eating such as obesity, cardiovascular disease, type II diabetes and some forms of cancer.
Having a strong religious faith can also benefit a person’s spiritual health and well-being by adding meaning to their life, creating a sense of hope and optimism and providing support during times of adversity.

Religious beliefs and practices may also have a negative impact on the health of people. Some religions forbid same-sex relationships and actively oppose acceptance of different sexual identities. This lack of acceptance and support may alienate same-sex attracted people of these religious faiths, leading to feelings of guilt, shame, confusion and isolation.

Culture
A variety of different cultures exist within society: cultures related to gender (such as male culture), age (for example, youth culture), location (for example, beach culture) and ethnicity are some examples of the cultures present in our society. Each of these cultural groups holds particular values, beliefs and assumptions that strongly influence the behaviour of its members and can significantly determine their level of health.

A person’s ethnic origins and place of birth can have both a positive and negative influence on their health status. Certain cultures may have particular diets or eating traditions that benefit health. For example, a traditional Asian diet tends to be low fat and healthy, with large amounts of grain-based foods (such as rice and noodles) and vegetables consumed daily and only small amounts of red meat. This reduces the risks of heart disease, certain cancers and diabetes. Other attitudes and values may contribute to behaviours that place health at risk. The NSW Schools Physical Activity and Nutrition Survey (SPANS) 2015 report found that students from an Asian cultural background were less likely to meet daily recommendations of physical activity, particularly girls, suggesting participation in physical activity may not be as encouraged and supported as it is among other cultural groups.

Language difficulties and cultural beliefs can create barriers that have a negative effect on health. Unfamiliarity with the Australian health-care system, a lack of fluency in English or cultural insensitivities can prevent or hinder migrants from accessing appropriate health care. Difficulties finding work due to limited experience, language difficulties or a lack of contacts can also see ethnicity linked to low socioeconomic status for some people who have migrated to Australia. This socioeconomic disadvantage tends to make it harder to achieve an optimal level of health. The health of some newly arrived migrants may be further affected by the hardships and trauma they have experienced prior to resettling in Australia. For example, many refugees may experience ongoing mental health issues as a result of violence and conflict they have witnessed or endured.

Being of Aboriginal or Torres Strait Islander descent also has a significant influence on health. Indigenous people experience much poorer health than other Australians. They have a much lower life expectancy, die at much younger ages and are more likely to have a lower quality of life as a result of experiencing ill health. Numerous factors relating to the living and social conditions of Indigenous people, along with significant levels of socioeconomic disadvantage and a reduced sense of control over their own lives, may help explain the poor health of Indigenous Australians.

Young people’s attitudes and beliefs can be a significant determinant in the health risks they are likely to experience. As discussed in topic 1, injuries are the leading cause of hospitalisation and death of people aged 15–24 years, with transport accidents and intentional self-harm responsible for many of these deaths. A desire to be independent, challenge themselves, experiment, have fun and fit in, along with feelings of invincibility may see young people engage in numerous high risk behaviours, that increase the likelihood they will be injured, such as binge drinking, speeding and travelling in overloaded cars. Many of these things are considered to be rites of passage from childhood to adulthood by some parts of society, leading to assumptions about how young people will behave. These assumptions can contribute to the attitudes that young people develop and can place direct or indirect pressure on them to conform to these expectations.
**FIGURE 2.11** Difference in health status and health behaviours of Indigenous and non-Indigenous people

**Age distribution of deaths, by Indigenous status, age and sex, 2009–2013**

Males

- 85+
- 80-84
- 75-79
- 70-74
- 65-69
- 60-64
- 55-59
- 50-54
- 45-49
- 40-44
- 35-39
- 30-34
- 25-29
- 20-24
- 15-19
- 10-14
- 5-9
- 0-4

Females

- 85+
- 80-84
- 75-79
- 70-74
- 65-69
- 60-64
- 55-59
- 50-54
- 45-49
- 40-44
- 35-39
- 30-34
- 25-29
- 20-24
- 15-19
- 10-14
- 5-9
- 0-4

Per cent of deaths

**Note:** Data are for NSW, Qld, WA, SA and NT

**Source:** AIHW National Mortality Database

**Age-standardised prevalence of selected health behaviours and risks, by Indigenous status, 2011–2013**

- Inadequate daily vegetable intake
- Not sufficiently active for health (non-remote areas)
- Inadequate daily fruit intake
- Risky alcohol consumption (single-occasion risk)
- Current daily smoker

**Source:** Australian Institute of Health and Welfare.
SNAPSHOT

Australia's drinking problem the focus of Australian Medical Association summit in Canberra

By Justin Huntsdale

The Australian Medical Association (AMA) wants the federal government to acknowledge Australia has a drinking problem, and will call for cultural change at a national summit in Canberra today.

Australia’s pride in its drinking culture is costing lives, harming unborn children, causing child neglect, fuelling domestic violence and giving the country a reputation it does not deserve, AMA president Associate Professor Brian Owler said.

The AMA will open the two-day National Alcohol Summit at the National Convention Centre in Canberra today. Its president is calling on the federal government to lead the way in changing our behaviour.

“We need the government to acknowledge there is an issue around alcohol, and it's not all about personal responsibility,” Associate Professor Owler said.

“We need to shape our attitudes and culture to make sure we minimise people's harmful alcohol consumption.

“We’re not against alcohol — we’re not prohibitionists or wowsers — but we need to make sure our children’s attitudes to alcohol are shaped properly.”

In Australia, there is a strong link between professional sport and alcohol advertising. Both State of Origin rugby league teams are sponsored by beer companies, while advertising breaks during sporting events on television are dominated by alcohol promotion.

“Our sporting identities are often the heroes of children, and we need to make sure we transition away from the sporting codes relying on alcohol advertising,” Associate Professor Owler said.

“You begin at the top and we have a government whose responsibilities do include shaping society’s culture and attitude around alcohol.

“It's [the alcohol industry] a powerful lobby group and they’re very well resourced.”

He said Australia’s drinking problem stretches further than the alcohol-fuelled violence reported in the news. Domestic violence, spousal abuse and child neglect can all often be traced back to alcohol abuse.

“What we’re doing today [at the summit] is giving a voice to people like victims who have been devastated by the consequences of alcohol,” Associate Professor Owler said.

“If we start this conversation on a national basis and get the government to acknowledge this as a responsibility, that’s the first step.”

Australia has examined several measures to stop alcohol-related problems, including raising the cost of ‘alcopops’, forcing venues to close earlier and implementing lock-outs after a certain time.

There has also been talk of raising the legal drinking age to 21, as is the case in the United States.

“The discussion around raising the drinking age distracts our focus on changing our behaviour around alcohol, and it’s not the best way to tackle the problem,” Associate Professor Owler said.

“It distracts from the way we’re brought up around drinking — the culture in Australia is to drink as much as you can and we’ve learnt to pride ourselves on it.

“Australians are much more sophisticated than that and we need to break some traditions.”


Inquiry

Attitudes towards alcohol in Australia

Read the snapshot ‘Australia’s drinking problem the focus of Australian Medical Association summit in Canberra’ and complete the following.

1. According to the Australian Medical Association (AMA), what is the culture around alcohol in Australia?
2. Describe the key health concerns raised by the AMA about Australia's drinking culture.
3. Sport is named as a contributing factor to cultural attitudes towards alcohol. Describe the role of sport in alcohol promotion and consumption.
4. Outline how ideas about mateship, masculinity and national celebrations (e.g. ANZAC Day) may also contribute to our attitudes towards alcohol.
5. Discuss the influence of other determinants (such as the media and geographic location) on patterns of alcohol consumption in Australia.
6. Do you agree with the AMA's assessment of Australia's drinking culture? Give reasons for your response.
2.1.3 Socioeconomic factors

The World Health Organization defines social determinants as ‘the conditions in which people are born, grow, live, work and age’. Furthermore they state that these determinants, which are significantly influenced by the distribution of money, power and resources, are largely responsible for the health inequities that exist within and between countries. A person’s socioeconomic status has a significant influence on the likelihood that they will be exposed to health risk factors, with increases in a person’s income, education and occupation level tending to be accompanied by improvements in their health.

This pattern of variation in health status, where people who are less advantaged in terms of socioeconomic position have worse health (and shorter lives) than those who are more advantaged, generally follows a gradient, commonly referred to as the social gradient in health. Evidence of this can be seen in figure 2.12, showing the mortality rates of people in different socioeconomic groups, and in tables 2.1 and 2.2, which compare health risk factors and chronic illnesses according to socioeconomic position. This information demonstrates that health status tends to be higher as socioeconomic position improves.

![FIGURE 2.12 The social gradient in Australia’s mortality](image)

**Source:** Australian Institute of Health and Welfare, *Australia’s health 2016*, fig. 4.1.2, p. 135.

<table>
<thead>
<tr>
<th>Table 2.1 Inequalities in selected chronic diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Back problems</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
</tr>
<tr>
<td>Coronary heart disease</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Lung cancer incidence</td>
</tr>
<tr>
<td>Mental and behavioural problems</td>
</tr>
</tbody>
</table>

(Continued)
TABLE 2.1 Inequalities in selected chronic diseases (Continued)

<table>
<thead>
<tr>
<th></th>
<th>Lowest socioeconomic group (per cent)</th>
<th>Highest socioeconomic group (per cent)</th>
<th>Rate ratio: lowest/highest socioeconomic group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral health rated as fail or poor</td>
<td>31.2</td>
<td>12.2</td>
<td>2.6</td>
</tr>
<tr>
<td>Stroke</td>
<td>1.1</td>
<td>0.5</td>
<td>2.2</td>
</tr>
</tbody>
</table>


TABLE 2.2 Inequalities in selected risk factors

<table>
<thead>
<tr>
<th></th>
<th>Lowest socioeconomic group (per cent)</th>
<th>Highest socioeconomic group (per cent)</th>
<th>Rate ratio: lowest/highest socioeconomic group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low birthweight</td>
<td>7.5</td>
<td>5.6</td>
<td>1.3</td>
</tr>
<tr>
<td>Daily smoking</td>
<td>20</td>
<td>6.7</td>
<td>3.0</td>
</tr>
<tr>
<td>Inactive or insufficiently active</td>
<td>76</td>
<td>56</td>
<td>1.4</td>
</tr>
<tr>
<td>Lifetime risky drinking</td>
<td>16.4</td>
<td>18.5</td>
<td>0.9</td>
</tr>
<tr>
<td>Overweight or obese</td>
<td>66</td>
<td>58</td>
<td>1.1</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>26</td>
<td>21</td>
<td>1.2</td>
</tr>
<tr>
<td>Participation of women aged 20–69 in cervical screening</td>
<td>52</td>
<td>64</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Source: Australian Bureau of Statistics and Australian Institute of Health and Welfare, Australia’s health 2016, table 5.1.1, p. 184

Education, income and employment are the key socioeconomic factors where disadvantage (either in one area or a combination of areas) is likely to negatively influence a person’s level of health.

**Education**

A person’s level of education has a significant impact on their health. Education enables people to obtain stable employment, have a steady income, live in safe and secure housing, provide for their families and make informed decisions about health care and health behaviours. The education level of parents affects not only their own health but also has a significant impact on their children’s health.

In addition to enhancing people’s knowledge and skills, education also serves to develop within the individual a sense of empowerment over their lives. This in turn increases the likelihood they will take action to improve their health.

Engagement in education also contributes to a sense of connectedness or belonging and provides young people with access to support if needed. On the other hand, school failure or leaving at an early age can make it more difficult to obtain employment, while also contributing to a sense of alienation and disconnection from society. Low levels of education, along with significant health problems such as mental health problems and substance abuse are commonly found in people who are imprisoned, highlighting the role that attaining an adequate level of education can play in supporting health.
Employment
Being able to secure satisfying, meaningful and regular employment is a protective factor for our health. Reports on the health of Australians have estimated that mortality rates are significantly higher for unemployed Australians than for those who are employed. Employment provides opportunities to be active, develop a positive sense of identity, interact with others and feel a sense of control over our lives, as well as ensuring a degree of financial security. Unemployment has been linked to stress, a loss of confidence, limited social contact, and feelings of depression and disempowerment, all of which significantly affect a person’s emotional and social health. Rates of self-harm, attempted suicide and suicide have been found to be higher in people unable to find work, particularly following extended periods of unemployment, while higher incidence of cardiovascular disease and lung cancer have also been linked with unemployment.

The type of occupation a person has can also determine their health. Jobs involving manual labour, such as trades or transport jobs, have higher rates of injury and death than clerical, managerial or professional occupations. The latter group, however, may be less physically active at work as their job involves large amounts of time sitting doing computer-based work. Long working hours can contribute to stress, reduce the time available for physical activity and make it hard to find a work–life balance, all of which affect a person’s health and well-being. Employment in certain jobs is also likely to result in exposure to high levels of pollution or increase the risk of coming into contact with harmful substances such as asbestos, chemicals or radiation.

Income
Those who have higher incomes have more money available to spend on products and services that provide health benefits, such as sporting or recreational activities, better quality food, private health insurance and alternative health services that can support good health. They have the freedom to choose from a greater range of options and the confidence of knowing they can afford whatever is needed to look after their health. This knowledge is likely to decrease stress and contribute to a sense of greater control over their life, which enhances psychological well-being.

Poverty, on the other hand, increases people’s exposure to risk behaviours likely to harm their health while also restricting their access to health services and reducing their capacity to modify their lifestyle. It also decreases the likelihood that people who are the most disadvantaged will live in safe, secure housing that is of an adequate standard. Those experiencing financial hardship tend to live in overcrowded conditions in communities with high population density, fewer transport and recreational facilities and less support services available. These living conditions add to the health risks faced by low income groups and further restrict their opportunities to seek help with health problems.

SNAPSHOT
Medical costs forcing Australians to skip health care
By Rania Spooner
Australians are paying five times more than Britons for medical care, causing many people with chronic health conditions to forgo treatment because it’s too expensive.
Nearly half of Australians living with depression, anxiety and other mental health conditions have skipped medication or therapy because of cost, according to a study by James Cook University and the NSW Bureau of Health Information.

As had more than 30 per cent of those with asthma and emphysema, 27 per cent of those with diabetes, 25 per cent with arthritis and 20 per cent of cancer patients, according to the study recently published in the Australian Journal of Primary Health.

Asthmatic Stephanie Horan, 27, was clinically dead for 12 minutes after she stopped her medication for social reasons and suffered a near-catastrophic asthma attack as a teenager.

Now she knows she can’t stop her medication and, depending on the severity of her symptoms, spends between $45 and $80 a month on medication, which does not include her GP, specialist appointments or machine upgrades.

‘It is expensive but with anyone else who has a chronic condition it’s your life,’ she said. ‘I’d hate to know they’re risking their life because it’s just too expensive ... to know somebody lost their life because they couldn’t breathe because their medication was too expensive.’

Lead study researcher Emily Callander, a health economist from the Australian Institute of Tropical Health and Medicine, said the US was the only country of 11 studied that had more people skipping health care due to cost than Australians.

Her team analysed the results of the 2013 Commonwealth Fund international health survey, which interviewed a cross-section of people from each country studied, including 2200 Australians.

‘In terms of skipping care we perform much worse than Canada and New Zealand, certainly the UK and Sweden,’ Dr Callander said.

Australian households were spending an average US$1026 each year on out-of-pocket medical expenses, compared to $216 in the United Kingdom and US$1844 in the United States, the researchers found.

‘We know within Australia and internationally that people with chronic diseases are most likely to have lower incomes so we’re getting this compounding of disadvantage,’ Dr Callander said.

Consumers Health Forum chief executive Leanne Wells said the study pointed to gaps in ‘Australia’s supposed universal health system’.

‘It also highlights the other vicious circle: that those with chronic conditions are more likely to have lower incomes and less wealth because of the exacerbating effect of their condition and their ability to participate in the labour force,’ she said.

‘Such findings highlight the emergence of a two-tiered health system and the need for reforms so that quality primary care for chronically ill people is available to all regardless of their income.’

Asthma Australia chief executive Mark Brooke said how to get cheaper medication was the most common inquiry they received. He said anecdotally they were aware of parents skipping their medication in some cases to pay for their children’s.

‘We need to be able to ensure that medications are more affordable for all Australians,’ he said.
Dr Stephen Carbone from beyondblue said: ‘We have been aware that roughly 50 per cent of those with mental health conditions do not access treatment, but believed this was largely driven by stigma.’ The possibility that cost could be a barrier to care was ‘a major issue that requires further investigation,’ he said. 

Source: Sydney Morning Herald, 4 August 2016.

Inquiry
Impact of income on health
Read the snapshot ‘Medical costs forcing Australians to skip health care’ and then complete the following.
1. Summarise the key findings of the study undertaken by James Cook University and the NSW Bureau of Health Information.
2. Identify groups in Australia that are likely to experience the greatest difficulty in affording the costs of health care.
3. Describe the potential health impacts of high health-care costs on people who are financially disadvantaged.
4. The study found those with chronic illnesses were likely to have lower incomes. Provide reasons for why these two factors may be linked.
5. Explain three other ways in which having a low income is likely to make it harder to achieve good health.

The high cost of certain health-care services means that the quality of care received by people varies according to their socioeconomic status. The Medicare system was designed to ensure that all Australians receive a certain level of health care. However, not all services are covered under the scheme (for example, dental care for adults) and waiting lists for procedures considered non-essential are long. Having to endure ongoing pain can lead to significant emotional distress, a reduced capacity to go about daily life, increased levels of stress for family and restrictions on social life, as well as physical discomfort, all of which significantly influence health.

It is not simply poverty that is likely to harm a person’s health. Being poor is often associated with negative stereotypes and images. For example, people who are homeless, long-term unemployed or suffering drug dependency issues are frequently labelled and looked at disapprovingly. The negative connotations that go along with experiencing poverty can also result in prejudice, discrimination and social exclusion that also work to influence a person’s health.

When discussing socioeconomic factors, the areas of education, income and employment should be considered in combination as they are all closely linked. An individual’s employment status is a major determinant of their income, while a person’s level of education plays a key role in their chances of gaining regular and
rewarding employment. Furthermore the *Australia’s health 2016* report noted that the social gradient can persist throughout life and extend into the next generation, meaning that many young people share the same level of advantage or disadvantage as their parents.

**SNAPSHOT**

**New report paints bleak picture of life for Australians on the breadline**

The Salvation Army is calling on both sides of politics to make poverty a key federal election issue after releasing disturbing new statistics on the level of poverty in Australia.

‘The key findings of a horrific new report paint a bleak picture of what real life is like for Australians on the breadline,’ says The Salvation Army’s Territorial Communications and Fundraising Secretary, Major Bruce Harmer. ‘We cannot keep putting a Band-Aid on disadvantage. We need serious funding to develop innovative solutions to the complex issues of entrenched poverty.’

Now in its sixth year, The Salvation Army’s *Economic and Social Impact Survey* (ESIS) surveyed more than 1380 clients across Australia.

It found that a massive 66 per cent of clients living in private rental properties or paying off a mortgage experience extreme housing stress — using nearly two-thirds of their disposable income on housing/accommodation.

Nearly one in five are either homeless or living in temporary accommodation — of these almost one in three previously privately rented. ‘What this tells us is that private rentals are not a secure form of housing for those living on the breadline,’ says Major Harmer. ‘One small change to an individual or family’s income, or an unexpected bill or expense can lead to a tenancy being lost and a family becoming homeless.’

The 2017 ESIS report reveals family violence is the leading factor in housing transiency. In fact, respondents affected by family violence were most affected by extreme housing stress. ‘We see very clearly from this research that many children are at significant risk of social exclusion because of generational poverty, unemployment and housing instability,’ says Major Harmer. ‘Having to move, sometimes numerous times a year, affects a child’s schooling, their ability to make and maintain friendships and their confidence.’

The report reveals:

- Respondents affected by family violence were most affected by extreme housing stress. And family violence is the key reason why women (23 per cent) moved in the past 12 months.
- 46 per cent of respondents who moved due to family violence said their children had to change schools when their family moved.
- 44 per cent of people who were surveyed had moved house — on average — almost three (2.7) times in 12 months.
- Nearly one in five (16 per cent) are either homeless or living in temporary accommodation (one in three previously rented privately).
- 37 per cent of people responding who are homeless had experienced persistent homelessness for two years (16 per cent had moved six times in the past 12 months).
- Of the 1495 children, 54 per cent were affected by severe deprivation.
- Single parents with children are the worst affected when it comes to the cost of living — surviving off just $14.35 per day.
- Some clients — on income support — survive off just $17.14 a day after housing/accommodation is paid for.
- Six out of ten respondents cannot afford an internet connection for their child.
- One in five cannot afford medical treatment or prescribed medicine for their children and one in three cannot afford a yearly dental check-up for their child.

Major Harmer says, ‘We need leadership and action from all levels of government. The results of this extensive survey of 1380 people are utterly shameful. It shows the real level of struggle taking place in our “lucky country”.

‘Now, more than ever, it’s time for Australia to reclaim our great Aussie spirit — of neighbours who care for their neighbours. The Salvation Army is committed to working with all levels of government, the private sector and other service providers to develop innovative solutions to intergenerational poverty.

‘Because when we walk beside people, it’s for the long haul. We believe hope is for everyone.’

2.1.4 Environmental factors

Environmental factors are those things present in the environment in which people live and work that can affect their health in a positive or negative way. These factors may relate to aspects of the geographic location in which people live, such as the design of the built environment, the quality of the air, food and water available, and the climatic conditions they commonly experience. Clean air, a regular supply of safe drinking water and the consumption of food that is properly stored and prepared can all promote improved individual and public health, while well-designed communities can assist to create safe, harmonious communities. On the other hand, poor building design, increasing levels of pollution and changes in climatic conditions all contribute to poor health by increasing the number of risk factors that people face and making it more difficult to choose healthier options. Access to quality health services and fast, reliable technology also influence a person’s level of health by making it easier to obtain accurate information about health issues and seek treatment and support when needed.

Geographic location

Studies into Australia’s health have found that people who live in rural and remote parts of Australia have poorer health outcomes than people living in major cities. They have lower life expectancy, higher rates of illness and injury, and higher levels of health risk factors such as smoking, being physically inactive, drinking excessive amounts of alcohol and being overweight or obese. Differences that are apparent in the health status of people living in rural areas compared with those living in urban and regional areas are complex and likely to be closely linked to other determinants of health, including socioeconomic factors and sociocultural factors. However, a number of factors specific to rural and remote environments play significant roles in determining the health of people living in these areas.

People living in rural and remote areas often have to travel long distances for work, household-related purposes and socialising. This can place them at greater risk of injury due to the dangers involved in travelling on country roads, which include long distances, poor road quality and factors such as speed, fatigue from driving long distances and animals on the road. They are more likely to face harsh living and working conditions and experience severe climatic conditions such as extreme heat, drought and floods that have the potential to negatively affect both physical and emotional health. Injury, disease, emotional distress and financial hardship are some of the health risks that can result from experiencing these weather conditions. The remoteness of communities and the distances between people may make it harder to create or maintain social support
networks. The sense of isolation and the difficulties finding emotional support when geographically isolated may contribute to poor mental health and depression.

While most Indigenous Australians live in non-remote areas, they make up a significant proportion of the population living in rural and remote areas. The poorer level of health of the Indigenous population discussed earlier in this topic is one factor behind the higher rates of illness and death in country areas. A number of issues relating to the geographic location of Aboriginal people who live in remote areas are likely to negatively affect their health. In particular the provision of safe, adequate housing that is supplied with electricity, clean running water and adequate sewerage systems remains problematic in some remote Indigenous communities. Disease outbreaks can occur when water becomes contaminated with harmful bacteria and viruses. Overcrowding and a lack of clean drinking water or adequate sanitation can accentuate health risks, particularly for babies and young children, and place people from these communities at risk of infectious diseases and poorer levels of health than other Australians.

Living in cities and large built-up areas may also affect a person’s level of health. High levels of air pollution are far more likely in major cities where there are more motor vehicles and industrial complexes. Poor air quality resulting from the production and release of poisonous emissions from vehicles and heavy industry increases the risk of respiratory infections, asthma, bronchitis and cardiovascular conditions. Smoke from bushfires and the burning of fossil fuels also decreases the air quality. People living in particular areas may face greater risks; for example, those living near major roads or industrial areas are likely to experience higher levels of air pollution, as well as more noise pollution and higher levels of traffic congestion.

Traffic congestion can contribute to high levels of stress as motorists become frustrated and angry. It also increases the likelihood of road crashes. Spending long periods of time driving to and from work also decreases the time people have available to be physically active or to be with their families.

People who live in cities and regional areas in most states and territories in Australia are more likely to be supplied with fluoridated tap water. The Australian Institute of Health and Welfare estimates that 80 per cent of localities in major cities have water supplies with adequate fluoridation, compared with 30–40 per cent of locations in regional areas. This percentage declines further in more remote locations. Studies of oral health have highlighted the significant differences in the oral health of children living in major cities compared to regional and remote areas, with the number experiencing tooth decay, missing teeth and filled teeth being substantially higher in regional and remote areas.

The built environment of major cities and regional areas may also determine a person’s health. The built environment refers to buildings and spaces that are constructed within communities. These include houses, shopping centres, public buildings, roads, railways, footpaths and recreational areas such as parks. Communities can promote health through careful planning and good design to ensure environments contain appropriate housing, transport infrastructure and facilities that encourage recreation and social interaction. The construction of cycleways and footpaths, along with the provision of adequate lighting, playgrounds, parks and other recreational facilities encourages physical and community activity. Adequate public transport also supports access to essential services, such as health care, while reducing the number of private vehicles on the road, thereby decreasing pollution levels, crashes and traffic congestion.
Inadequate or ill-conceived planning, however, can work to harm health by exposing people to dangers or discouraging behaviours that promote improved health. For example, the small size of newly released house blocks, along with the design of homes built on these blocks, is contributing to increasing rates of obesity because small backyard areas provide little space for children to play, while large indoor entertainment areas encourage passive activities such as playing computer games and watching giant-screen televisions. The location of industrial complexes has to be carefully considered to ensure residents are not harmed by increases in pollution, traffic volume and possible chemical leaks or accidents.

The creation of high-density housing estates can play a part in the spread of infectious diseases, while overcrowding can also contribute to disputes, tension, social unrest and violence within the community.

**Access to health services**

The ability to access appropriate health care at times of need is an important factor in maintaining good health. However, certain groups can find it difficult to access services and support when required. People who are geographically isolated have poorer access to and use of health care and specialised treatment services than those in major cities and large regional centres. Services are more likely to be under-resourced or unavailable due to the difficulty of attracting and retaining health professionals in these areas. Those in remote areas particularly may rely on health care provided by the *Royal Flying Doctor Service* or other outreach services that visit communities on a rotational basis. They may also depend on medical support provided by phone or videoconferencing, particularly in emergencies. In these situations, people may be required to administer their own first aid or medical treatment under instruction, because of the time it takes for medical services to arrive.

The range of health-care options in rural and remote areas is less than in urban areas. Access to preventative health services like screening programs and support groups is limited, and GPs may find it difficult to access training to update their knowledge or obtain new skills (such as counselling) to assist patients with mental health needs. Along with this, the lack of alternative health professionals, such as acupuncturists and chiropractors working in country areas, means that choices about health care can be restricted. Specialised treatment services are also limited, meaning that people may have to wait longer for health care or travel long distances to receive the necessary health care. Those with ongoing conditions may be required to be away from home for long periods of time while undergoing treatment, resulting in distress and financial hardship. While a strong sense of community in rural areas can help provide a network of support, the small size and closeness of these communities can lead to concerns about confidentiality and privacy when seeking health care. A fear that ‘everyone will know’, coupled with stigma associated with certain health conditions such as mental health or sexual health issues, can make people reluctant to seek help and treatment when needed.
SNAPSHOT

Rural health-care concerns highlighted in Royal Flying Doctor Service survey

By Anna Vidot

Rural and remote Australians remain deeply concerned about poor access to health care, and want the federal government to spend more to fix the problem. That is the key finding from the latest Royal Flying Doctor Service (RFDS) research, released on Tuesday. The RFDS surveyed more than 450 country Australians, and one-third nominated access to doctors and specialists as their single biggest health-care concern.

A third of respondents called for more government funding of services, particularly for mental health and preventative care.

RFDS chief executive Martin Laverty said it raised a question for governments as to whether policies aimed at bridging that gap had failed.

‘We have an oversupply of doctors in this country; the problem is, the doctors are simply not all working in areas where they’re most needed,’ he said.

‘It brings into question the success of repeated programs of Commonwealth governments to encourage doctors to work in remote and country Australia.

‘The question for government is, are our incentives for doctors sending them to where they’re most needed?’

Access to doctors in remote areas a challenge

The survey found encouraging news in other areas.

Two-thirds of respondents said they needed to travel for one hour or less to see their GP or another non-emergency medical professional.

But for Australians living in more remote places, a visit to the doctor could mean a 10-hour round trip or more. RFDS chief medical officer in Queensland Abby Harwood said governments could do other things to improve their access to care beyond putting more bodies on the ground.

‘There is a lot of telephone and email consultation going on between people out bush and their GPs, but that requires actually having a pre-existing relationship with a health-care provider who knows you,’ she said.

‘Technology such as video-conferencing is a fantastic opportunity, [but] currently the telecommunications infrastructure out in these areas is not quite sufficient to be able to do that reliably.’

GPs not paid by Medicare for teleconference consultations

Unlike specialists, who can bill Medicare for video-conferencing consultations with patients, GPs currently are not paid unless their patient attends a consultation in person.

Dr Harwood said that meant GPs who assisted remote patients over the phone or by teleconference were doing so on their own time and usually out of their own pocket.

‘From my experience, most of us would just do it [for free] out of the service that we provide,’ she said.

‘At the moment it’s either the health-care provider doing it for free, or the person accessing the GP is paying for it out of their pocket with no subsidy.

‘When you consider the petrol bills, how much it costs in fuel to drive a 1000 kilometre round trip, a lot of them would rather pay out of their own pocket to do that [if the doctor is not already doing it for free].’

Dealing with issues before crisis point

Dr Harwood seconded the call for a greater focus on preventative care for rural and remote patients, who were too often only dealing with medical issues once they had reached crisis point.

She said changing that made medical and economic sense.

‘[When there’s a crisis] a patient then has to travel in and out of their regional centre or capital city, which obviously causes a lot of disruption and it’s expensive,’ she said.

‘I don’t think anyone has actually measured the full cost to Australia as a country, taking into account that social dislocation and the economic disruption when people need to leave their properties, leave their workplace.

‘It’s been proven over and over again that good primary health care, delivered to people out there on the ground, can often prevent those crises from happening.’

Significant boost in GP numbers ‘in all areas’

Assistant Minister for Health David Gillespie, who has responsibility for regional health issues, is on leave.

But in a statement, a federal Department of Health spokeswoman said there had been a significant boost in GP numbers ‘in all areas of Australia’ over the past decade.
A 2017 budget announcement included funding of $9.1 million over four years from 2017–18 to improve access to mental health treatment services for people in rural and regional communities,” the statement read.

“Currently, Medicare provides rebates for up to ten face-to-face consultations with registered psychologists, occupational therapists and social workers for eligible patients under the Better Access initiative.

“From 1 November 2017, changes to Medicare will take effect so that seven of the ten mental health consultations can be delivered through online channels [telehealth] for eligible patients, that is, those with clinically diagnosed mental disorders who are living in rural and remote locations.

“Relevant services can be delivered by clinical psychologists, registered psychologists, occupational therapists and social workers that meet the relevant registration requirements under Medicare.”


Inquiry

Difficulties faced by those living in rural locations

Read the snapshot ‘Rural health-care concerns highlighted in Royal Flying Doctor Service survey’ and then complete the following.

1. Outline the key issues people living in rural and remote areas face in accessing health care.
2. The report highlighted the importance of patients having a pre-existing relationship with their GP. How will a pre-existing relationship between doctors and patients help provide good health care? Why may this relationship not exist as frequently for rural and remote Australians?
3. Describe the potential impact of poorer access to health care on the health of rural and remote Australians. Name specific illnesses they are more likely to experience.
4. Use the Australia’s Health 2016: Rural and remote health weblink in the Resources tab to read the findings on the health of rural and remote Australians (section 5.11 of the report). Compare these findings to your answer to question 3.

People living in major cities can also experience difficulties accessing health care, especially those who rely on the public health system. High demand, particularly in areas of population growth, can result in insufficient hospital beds being available or long periods waiting to be treated. For patients without private health insurance, the waiting lists for procedures considered non-essential (for example, knee replacements) may be lengthy, meaning they may experience ongoing pain and distress for some time before being operated on.

Access to technology

Increasing use of technology, such as computers, tablets, mobile phones and electronic games, has impacted significantly on people’s health, particularly the health of young people. Studies have found that a large proportion of young people spend significant amounts of time involved in small screen recreation; that is, playing computer games, social networking, using the internet and watching TV shows and movies via streaming services. This regular use of technology often comes at the expense of physical activity. Excessive TV watching and small screen recreation tends to reduce the time available for physical activity and increase the time spent being sedentary. These prolonged periods of being inactive are associated with an increased risk of overweight and obesity.
Inquiry
Technology and my health

Australia’s Physical Activity and Sedentary Behaviour Guidelines for Young People advise that no more than two hours a day should be spent using electronic media for entertainment. Calculate the amount of time you usually spend each day using small screen recreation and compare this to the guidelines. Use the results of this comparison to discuss the impact that your use of technology during leisure time could have on your health.

Advances in technology have helped address some problems associated with living in rural and remote areas, particularly the distance involved in accessing health services and the scarcity of health resources available. The increasing use of electronic devices and improved access to the internet has provided people in rural and remote areas with greater access to accurate health information that can support improvements in their knowledge and awareness of health issues. It has also helped medical professionals working in remote locations keep up to date with the latest research and advances, without having to leave their practice to attend training and professional development.

Texting, instant messaging and other internet-based communication platforms have reduced people’s sense of isolation by allowing them to keep in touch easily and cheaply. This technology also allows doctors in remote locations to quickly and easily communicate with patients and consult with health-care providers in different locations, thereby reducing the time and travel needed to access health care. The development of scanners and digital imaging technology has also reduced the time people are required to spend away from their work and family. Images are sent to remote locations for interpretation, instead of the person having to stay in larger cities and towns while they are diagnosed.

Improvements in mobile phone and broadband coverage have also provided people in rural and remote areas with greater access to health services and reduced the time taken to get medical help. The Royal Flying Doctor Service of Australia reports that the remote consultations it provides are now primarily conducted via phone and video-conferencing rather than radio. The portable nature of mobiles means that medical assistance can be accessed faster in emergency situations.

Web-based services, such as eheadspace and ReachOut.com have also allowed people to access online health care and support when services may not be available in their local area, at any time of day or when people feel more comfortable maintaining their anonymity. Mobile phone apps are another technology-based source of information and tools to support good health. The availability of these free, private services gives people a safe and confidential way of discussing issues affecting their health, accessing support and developing self-help strategies.

A number of difficulties still exist that limit or prevent the effective use of technology to support people’s health. Lack of infrastructure, particularly in rural and remote areas, can restrict people’s access to fast and reliable technology. The cost involved in purchasing a mobile phone, electronic device or personal computer and associated software and connection fees can be unaffordable for some people, particularly those who are most financially disadvantaged. Computer illiteracy and reduced access to support services such as technical support and repairs can also limit the usefulness of technology for those who live in rural and remote communities.
Climate change
Global warming and the depletion of the ozone layer could potentially bring about further health concerns in the future. A love of outdoor activities, particularly those based around water, coupled with already high levels of UV radiation in Australia is likely to see increasing incidence of sunburn as ozone depletion brings about further increases in UV radiation. Research has also predicted that rises in temperatures in the future will be accompanied by an increasing number of deaths from heat-related illnesses, with anywhere between 8000 and 15 000 people per year predicted to die by 2100 (Woodruff et al. 2005).

Tobacco smoke
Tobacco smoke is a form of environmental pollution that has a particular effect on people’s health. Tobacco smoke can be inhaled from both the end of a burning cigarette and from the smoke exhaled by the person smoking. Commonly called passive smoking, the inhalation of this environmental tobacco smoke leads to numerous harmful health effects on people who are exposed to it, including increased risk of respiratory disease and cardiovascular disease, decreased lung function and increased incidence and severity of asthma attacks. Government legislation has banned smoking in most indoor buildings and areas such as pubs, restaurants, public transport and sporting venues, thereby reducing the risks people face from environmental tobacco smoke. However, smoking inside homes and cars can still place people at risk from passive smoking, with the health of babies and young children particularly affected.

Application
Impact of the determinants on people’s health
Create a table like the one below. Consider how each determinant can have a positive and/or negative influence on a person’s health. Make a specific point about how each determinant can influence health, and support your point with a clear example. An example has been provided for genetics to demonstrate the detail needed to ensure your information and examples are clear.

<table>
<thead>
<tr>
<th>Determinants of health</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual factors</td>
<td>Genetics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Genes can provide people with potential in terms of their physical abilities and intellectual capacity. This can increase their chances of successful sporting participation and academic success (e.g. children of professional athletes often become good athletes themselves).</td>
<td>- Various genetic disorders can be passed on at birth. These can lead to chronic ill health and lower life expectancy (e.g. Down Syndrome and muscular dystrophy).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Certain diseases are genetically linked and can run in the family. This makes those with a family history of such diseases more likely to develop these diseases (e.g. heart disease, breast cancer, asthma and diabetes).</td>
</tr>
</tbody>
</table>

(Continued)
## Determinants of Health

<table>
<thead>
<tr>
<th>Determinants of health</th>
<th>Positive</th>
<th>Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge and skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sociocultural factors</td>
<td>Family</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Peers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Media</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Culture</td>
<td></td>
</tr>
<tr>
<td>Sociocultural factors</td>
<td>Education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Income</td>
<td></td>
</tr>
<tr>
<td>Environmental factors</td>
<td>Geographic location</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access to health services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Access to technology</td>
<td></td>
</tr>
</tbody>
</table>

---

### SNAPSHOT

**GPs failing to help obese patients lose weight after mistaking low health literacy for laziness, new research finds**

**By David Taylor**

GPs are failing to help obese Australians lose weight because they are mistaking low levels of health literacy with a lack of motivation, according to new research.

The University of New South Wales researchers found that one in five Australians simply do not understand how to lose weight and GPs need to do more in the battle against Australia’s obesity epidemic.

But fitness experts argue it is unfair to target doctors who do not have the time to effectively treat many of the underlying problems of obesity.

The UNSW researchers examined how GPs and practice nurses managed overweight and obese patients with low health literacy in 20 practices in Sydney and Adelaide.

The study found only a few of the 61 health staff surveyed reported assessing a patient’s health literacy.

**Australians have trouble understanding how to lose weight**

Around 14 million Australians are overweight or obese, according to Monash University, and Emily Jackson from Perth is one such person who struggled with weight loss for years.

After following an intensive training program, she now has a healthy body mass index.

“It’s incredibly hard but after a few months of being really, really intensive with my eating and with my exercise, it’s just become second nature,” Ms Jackson said.

Ms Jackson sought the help of a full-time trainer for her weight problem, rather than a general practitioner.

“GPs tend to strike me, or the ones that I see, they tend to strike me as not necessarily fit people,” Ms Jackson said.

“Yes, they have an understanding about nutrition but that’s only a very small part of what goes into a weight loss journey.”

Academics say GPs have a responsibility to effectively communicate with people about how to lose weight.
‘The real issue is in terms of effectively communicating what to do about it,’ said Professor Mark Harris, the director of the Centre for Primary Health Care at the University of New South Wales.

He said many Australians who struggled with obesity often had trouble understanding how to effectively lose weight.

‘It’s more how to deliver it to a patient who perhaps is from a low educational background or ... they’re from another language group,’ he said.

Professor Harris said that around three in five Australians were not as aware as they could be about how they could effectively lose weight, and one in five Australians actually had low health literacy.

GPs don’t have time to talk about weight loss
Fitness experts say tackling obesity is far too big a problem for GPs to fix.

Personal trainer Marnie Ross spends her days helping and educating people on how to be healthier.

‘You’ve got your fast food restaurants all over the place, you’ve got chocolate bars at the counter when you’re checking out, it’s just in your face all the time,’ Ms Ross said.

‘So people that don’t have that self-control and they have that addiction to food, [they] can grab-and-go anytime.’

Professor Harris argues that it is a medical problem and that it needs to be discussed in the clinic.

‘The GP needs to ask patients what they’ve understood but not as a test of the patient but a test of the GP’s ability to explain that,’ Professor Harris said.

Ms Ross argues there is simply not enough time during a standard consultation with a GP to effectively discuss how to lose weight.

‘If they only have a very short period of time to speak with a patient, you’re not going to get results from that,’ she said.

Professor Harris is currently assessing how the National Health and Medical Research Council guidelines can be best incorporated into GP practices.


Application
The impact of health literacy on people’s health and behaviours
Read the snapshot ‘GPs failing to help obese patients lose weight after mistaking low health literacy for laziness, new research finds’ and then complete the following.

1. Using examples from the article, explain how a combination of various determinants affect a person’s ability to lose weight.
2. Which other determinants not mentioned in the article could also influence people’s ability to lose weight? Using examples, explain how.
3. Doctors and personal trainers were two groups highlighted in the article who can help people wanting to lose weight. Which groups would find it harder to access their support? Give reasons why.

2.2 The degree of control individuals can exert over their health
Many of the health problems that are currently prevalent in Australia are linked to the decisions people make about their health and the lifestyle that they lead. However, a person’s level of health is not solely determined by their individual choices. Nor does everyone have the same opportunity to easily make and carry out decisions that will improve their health. A range of social, economic, environmental and individual factors, which are often interrelated, all exert a considerable influence over the health choices we make and our chances of being healthy. People with economic, social and educational resources are in a better position to take action
to promote their health than those who do not have access to these resources. If we have power and status within our social situation, we feel a greater sense of control over our life so are more likely to take action to improve it. Therefore the degree of control that we are able to exert over our health depends on the degree to which we can control or modify these influences.

Not all Australians are able to exert the same degree of control over their health, which has resulted in inequalities arising in the health status of particular population groups. Those who experience considerable disadvantage, such as Aboriginal and Torres Strait Islanders, people from low socioeconomic groups and people living in rural and remote areas, find it hardest to exert any influence over the things that determine health, therefore they are likely to face the greatest difficulties looking after their health.

2.2.1 Modifiable and non-modifiable health determinants

Health determinants can be classified as modifiable or non-modifiable, depending on the degree to which they can be changed, influenced or controlled by the individual.

Modifiable health determinants

Modifiable health determinants are those determinants that can be changed or controlled so they have a different level of influence on our health. Our ability to modify particular determinants of health and change our health behaviours depends on the sense of control or empowerment we feel we have over our lives. Control over our health increases when we believe we can:

- acquire information
- make choices
- manage a situation that may be threatening
- use the skills we possess.

The mutual relationship between the individual and their social and economic circumstances is central to the control we are likely to exert over our health. Being in a position of socioeconomic advantage provides us access to physical and social resources such as education, money and health services that can make our life better. This access contributes to our sense of empowerment. People who feel in control of their lives are more likely to take control of their health. For some people, modifying the socioeconomic determinants that influence their health, such as education, employment and income, can be difficult. Their sense of empowerment and overall outlook on life can help them to overcome barriers created by their socioeconomic conditions and change their health behaviours.

One of the most important factors that allows us to take control of our health is our sense of self-efficacy. As explained, self-efficacy refers to our belief in our ability to bring about change. The stronger our self-efficacy, the greater our levels of perseverance and persistence and feelings of control. If we have low self-efficacy we are more likely to feel powerless and produce negative self-evaluations that can lead to lower self-esteem.

The health knowledge and skills that people possess is one area that can be modified to enable them to assert greater control over their health. Reliable and accurate information on issues such as how to prepare healthy meals, or ways to increase our level of activity is often available in places such as doctors’ surgeries, local newspapers and on the internet.

Many health organisations offer information in the form of pamphlets, websites or public forums to enable people to improve their knowledge of particular health issues. For example, the Family Planning Association website contains a range of fact sheets on contraception, sexually transmitted infections and other sexual health matters. These organisations can also support the development of skills. For example, the Quitnow website offers information and suggestions on how to effectively quit smoking and provides various online tools and resources such as Quitcoach and My QuitBuddy app, and access to services such as the Quitline that support people wanting to stop smoking. The provision of this information and support can allow people to gain a deeper understanding of issues that may affect their health and develop strategies to enable them to be successful in quitting.
However, the degree to which people can improve their knowledge varies. Not everyone will have the literacy required to be able to understand the information available, or to determine which information is credible and reliable. Nor will everyone have the same level of access to this information. Groups who experience the most disadvantage, such as the long-term unemployed, homeless or some Indigenous people, are likely to find it most difficult to improve their health knowledge and skills due to their isolation from the community and their education level.

People also need to possess an interest or desire to improve their health knowledge and skills in order for this to occur. Health is not always the central consideration when people make decisions; it is just one of a range of factors. For many people, the long-term consideration of health often takes a very distant second place to the immediate demands and pressures of daily survival. Others may be unaware of the risks present in their environment or the harms linked to their current lifestyle, so are not looking to learn more about their health and how it can be improved. A variety of barriers therefore exist that hamper people’s ability to change their knowledge and skills.

People’s attitudes to health are another determinant that may be modified. Different experiences and events during our lifetime, such as being diagnosed with skin cancer or losing a friend in a road crash, may lead to a change in our health attitudes. Health promotion campaigns are a commonly used strategy that seek to change people’s attitudes and challenge their beliefs. An example is the Towards Zero road safety campaign which aims to highlight the human element of the road toll, encourage road users to change how they think about road safety and remind drivers of their responsibilities when behind the wheel in order for the target of a zero road toll to be achieved.
The likelihood that individuals will change their attitudes and thereby improve their health varies according to a number of factors. A person’s self-efficacy has a significant influence on the likelihood of change occurring because it affects their beliefs about whether they are capable of behaving differently. For example, a person who thinks that they are hopeless at sport will find it difficult to increase their level of participation unless they believe that practice and ongoing involvement will help them improve.

An individual is also more likely to change their attitudes when they can recognise there are significant benefits from doing so. The support of others, particularly those closest to us, is another crucial factor in the likelihood of changes in attitude occurring. For example, someone who is overweight is more likely to seek to lose weight if others encourage and support them, and if they recognise how much healthier they will feel as a result.

A person’s age may also affect their likelihood of changing attitudes. The need to feel that they ‘fit in’ or belong may make it difficult for young people to change their attitudes if these attitudes are markedly different from those of their peers. Attitudes and beliefs about health-related matters may also become more fixed as people age, making them reluctant to change their health behaviours.

Community attitudes, which are strongly influenced by particular aspects of society such as the media, religious beliefs and cultural expectations, are outside our direct control. However, we do have control over the extent to which we are influenced by those around us, such as our families and peers, and the extent to which we conform to stereotypes or expectations. We are able to hold different beliefs to those commonly held by our peers or by the community and we can choose to behave differently from others. We may also choose to challenge particular views, behaviours or decisions in an effort to change attitudes that may be limiting good health. For example, we could start a social media campaign to discourage online bullying and trolling, or advocate for a ban on excessively thin models featuring in magazines and fashion shows.

Attempting to challenge the attitudes, values and behaviours of families is particularly difficult for children and young people as it is often not appropriate for them to challenge the health-related decisions of their parents. It is also unlikely that they would have the confidence, assertiveness and communication skills necessary to do so or a sufficient level of knowledge to recognise possible concerns associated with particular attitudes and behaviours. As we become older it may become easier to challenge particular attitudes or make our own choices, independent of the beliefs or decisions of our families.
Non-modifiable health determinants

Non-modifiable health determinants are determinants that cannot be changed or altered. The only factors that might be seen as non-modifiable determinants of health are genetics or heredity and some environmental factors.

Genetics

The genetic material we receive from our parents can pass on certain health conditions, increase our susceptibility to particular illnesses or see us inherit characteristics that can affect our health. This genetic material cannot be altered, although tests for certain conditions such as Down syndrome can be performed prior to conception or during pregnancy. Progress in the treatment of particular genetic conditions has meant that people born with conditions that used to be life-threatening, such as haemophilia, can generally now lead healthy, normal lives. People with a family history of a particular illness such as breast cancer can also undergo monitoring, screening and surgery before any symptoms are detected in an effort to reduce the risk of cancer developing.

Environmental factors

Where and how people live is, in most cases, dictated by what people can afford, where they work and what facilities are provided for them in these places, meaning that environmental factors are largely non-modifiable. People who live in rural and remote areas have little control over the limited health services that are available, the sparse infrastructure, the occupational health hazards that are present, the social isolation that exists or the natural disasters that occur.

Similarly, people living in areas surrounded by heavy industry or high volumes of traffic have little control over the levels of air pollution that may be present in their environment. While it is possible for individuals to take precautions to reduce some risks, such as staying indoors when high levels of pollution are present, these measures do not remove long-term risks.

Individuals may also seek to modify aspects of their environment by lobbying governments for increased expenditure for health services or tighter controls on factory emissions. This is more likely to occur when people have high levels of knowledge and feel empowered to initiate change. However, the fact that poor environmental conditions generally exist in areas of lower socioeconomic status means that people may not have sufficient knowledge, skills and self-efficacy to take effective political action.

SNAPSHOT

Obesity and urban sprawl: Is life in the outer suburbs making us fatter, sicker?

By Sarah Collard

Australia’s ever-expanding cities have been linked to weight gain and chronic illnesses, sparking calls for a more integrated approach to designing healthy neighbourhoods.

Researchers from Australian Catholic University’s Institute for Health and Ageing examined how neighbourhoods could make healthier residents by focusing on everyday activities like heading to work and shopping.

They found people in outer suburban areas gained weight faster than those in inner-city neighbourhoods, and suggested it could be linked to a greater dependency on cars.

Experts are now calling for Australia to reconsider its urban development plan to build healthier, more active cities, with a focus on public transport and higher density living.
"We tracked more than 2000 adults living in urban and suburban areas of Adelaide and measured their waist circumference twice over four years," lead researcher Takemi Sugiyama said.

"What we found was that weight gain was not evenly distributed."

"Our daily behaviours, such as commuting to work and shopping, can contribute to obesity over time ... and people living in outer suburbs tend to rely on cars and are much more sedentary for these daily tasks.

"In contrast, people living in inner city areas appear to be more active, maybe because they have more transportation options and shops are closer."

Promoting ‘more active lifestyles’

Professor Sugiyama said governments, urban planners and health sectors needed to work together to create healthier neighbourhoods.

"It’s about creating compact residential and commercial areas around transportation hubs to allow for more active lifestyles for residents," he said.

"We have to start thinking about urban sprawl and the negative health impacts because it can have serious implications in the next decade.

"Obesity is going to increase if people live in outer suburbs, and obesity is a major risk factor for chronic conditions such as heart disease, diabetes and cancers."

Better public transport needed

Creating reliable, fast and well-integrated public transport systems was one way to reduce Australia’s stranglehold on cars, researchers said.

Cities in Japan and Europe actively encourage public transport and create suburbs and transport options to support active living.

"Tokyo is a good example of a very good transportation network — people don’t need a car to get to places. And most European cities have good transport options, and some cities discourage car use through congestion surcharges," Professor Sugiyama said.

"Obviously you need a reasonably dense population, but Australia does need to start thinking about urban sprawl and its negative health impacts."

Inequities of man-made natural disasters

Low-lying cities and towns near coasts are facing increased risks from more frequent and more intense cyclones. These storms can generate storm surges causing flooding, direct injury and damage to infrastructure, including housing, water and sanitation systems.

Poorer households are usually at higher direct health risk due to weaker structures, less safe locations and building sites, and the weaker resilience of infrastructure in poorer cities and towns to withstand damage.

At the end of 2013, the Philippines were hit by devastating super typhoon Haiyan, which affected 16 million people. 6069 people were reported dead while 4.1 million people were displaced, with 1.1 million houses damaged or destroyed. While everyone was touched by the typhoon, large income inequalities meant that poorer people not only lived in poorer quality housing, they were also more likely to be living on cheaper land in vulnerable low-lying regions.

Poorer households also often lack the economic resources to evacuate in the face of climate-related disasters, or to rebuild. The flooding of New Orleans in 2005 gave a striking example of what can happen among socially disadvantaged communities. Elderly patients in homes and poor people could not evacuate in front of the storm because of lack of transport.

We see similar issues with heatwaves. Lower socioeconomic and minority ethnic groups are more likely to live and work in warmer neighbourhoods and in buildings that are poorly ventilated and absorb heat. This increases the risk of heat stress and heat deaths.

Poorer communities with little green spaces are likely to be more exposed to high temperatures compared to more affluent neighbourhoods.

Impacts on agriculture

Our agricultural systems are also under threat. Increasing drought periods in Australia may challenge the viability of agriculture in some regions, and hence those communities that depend on primary production. This will affect people’s income, stress levels and sense of hope.

In 2003 bushfires ravaged eastern Victoria, destroying more than 40 homes and killing thousands of cattle. But the bushfires exacerbated problems already present in the community, typical of other rural Australian communities. Economic and climate pressures on rural farming communities have created financial hardship, led to closures in local businesses, and young people moving away.

This has transformed the social landscape and support that is often present within rural communities. These factors we know have real implications for mental health and may increase risk of suicidal thoughts.

Climate change also exacerbates food insecurity. Modelling estimates suggest that between 2005 and 2007 there was a 33 per cent increase in the price of vegetables and a 43 per cent increase in fruit prices in Australia because of the drought and extreme weather events.

Rising food prices most affect the poor — as a proportion of total household expenditure, food makes up an average of around 19 per cent. But, with 12 per cent of Australians living below the poverty line, these average figures hide some of the food security difficulties many Australians face.

Climate pressures will widen the food gap between those able to maintain a healthy diet of fresh produce, fish, lean meat and so on, and those needing to find the cheapest sources of calories. Cheap calories are found in the most highly processed, long shelf-life products, containing hardened fats and bulk starches, preserved with sugar or salt.

Source: Extract from The Conversation, 15 August 2014.

Inquiry

Climate change and health

Read the snapshot ‘Climate change will widen the social and health gap’ and then complete the following.

1. Summarise how weather events exacerbated by climate change are predicted to affect health.
2. Explain why the health of Indigenous people and low socioeconomic groups is more at risk from climate change than that of high socioeconomic groups.
3. Discuss to what extent people are likely to have control over their health if the predictions of health experts prove to be correct.
2.2.2 Changing influence of determinants through different life stages

The level of influence that the various determinants have on our health will not always be the same. At different times in our lives certain determinants may have a greater or lesser influence on our health status and health decisions. Babies and young children have minimal direct control over the various determinants as they rely on their parents or caregivers to look after their health and wellbeing. Factors relating to their families such as their socioeconomic status and geographic location, along with the decisions made by their parents, will largely determine a child’s health in their early years of life.

As we get older and start interacting with others beyond our immediate family, other sociocultural influences such as the media can start to have a significant influence on our health. Even at a young age the media is able to exert a powerful influence over things such as children’s eating habits and choices. Concerns that advertising of fast food contributes to increased consumption of these foods has prompted debate about whether restrictions should be placed on advertising these products during children’s television programs.

Celebrities such as models, movie stars and singers feature heavily in types of media popular among young people (for example, social networking sites like Instagram, Facebook and Snapchat), so their behaviour, attitudes and appearance can have a significant influence on the health-related values, decisions and behaviour of adolescents, although this influence may occur subconsciously. As we become older our health literacy skills and knowledge generally improve, assisting us to question the credibility and reliability of information and be more critical of media images. Life experiences may also see us increasingly question the information and messages communicated through the media, thus reducing the extent of its influence.
Feeling a sense of belonging with their peers is important for a young person’s identity and emotional well-being, so peers commonly have a strong influence on health during adolescence. Social pressures to behave in particular ways or to conform to certain expectations may lead some young people to experiment and take risks in relation to their health that can impact on their immediate and longer term well-being. For example, they may experiment with drugs, drive in a fast, dangerous manner, or participate in various sexual activities. Statistics regarding these behaviours show that the incidence and frequency of these behaviours decreases as people move through adulthood, suggesting a change in the influence of various determinants.

**Application**

**Changing patterns of drug use at different life stages**

Use the National Drug Strategy household survey weblink in the Resources tab to investigate changing patterns of drug use.

1. Investigate one of the following drugs:
   - tobacco
   - alcohol
   - ecstasy
   - cannabis

   You may also examine table 2.3 and figure 2.26 below showing a comparison of recent use of these drugs by different age groups.

2. Looking at the findings from the 2016 survey, identify the percentage of people in the different age groups who indicated they used tobacco daily, consumed alcohol at very high levels, or recently used cannabis or ecstasy. Present your findings as a line graph. Create separate line graphs to show use by males, females and all people.

3. Discuss how:
   (a) use of this drug may have been influenced by the various determinants
   (b) changes in the influence of these determinants may account for the patterns of use that are shown in your graph.

<p>| TABLE 2.3 Proportion and per cent change of people smoking daily, by age and sex, 2001, 2013 and 2016 |</p>
<table>
<thead>
<tr>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group</td>
<td>2001</td>
</tr>
<tr>
<td>12–17</td>
<td>n.a.</td>
</tr>
<tr>
<td>18–24</td>
<td>24.5</td>
</tr>
<tr>
<td>25–29</td>
<td>30.9</td>
</tr>
<tr>
<td>30–39</td>
<td>26.9</td>
</tr>
<tr>
<td>40–49</td>
<td>23.4</td>
</tr>
<tr>
<td>50–59</td>
<td>20.1</td>
</tr>
<tr>
<td>60–69</td>
<td>12.7</td>
</tr>
<tr>
<td>70+</td>
<td>7.0</td>
</tr>
<tr>
<td>14+</td>
<td>20.9</td>
</tr>
<tr>
<td>18+</td>
<td>21.8</td>
</tr>
</tbody>
</table>

*Note:* The 2001 survey did not include 12–13-year-olds.

FIGURE 2.26 Changing patterns of drug use at different life stages

(a) Consumption of 11 or more standard drinks at least monthly, by age, people aged 12 or older, 2010–16 (%)

(b) Recent use of cannabis, by age and sex, 2001, 2013 and 2016 (%)

(c) Recent use of ecstasy, by age and sex, 2001, 2013 and 2016 (%)

Source: Australian Institute of Health and Welfare, National Drug Strategy household survey 2016: Detailed finding, pp. 41 (fig. 4.5), 62 (fig. 5.7) and 66 (fig. 5.9).
Changes in values and priorities may also play a role in the changing health attitudes, decisions and behaviours evident in these statistics. These changes may come about for a number of reasons, including:

- **biological changes to the brain.** Adolescence is a stage of life when brain development and reshaping continues to occur, affecting young people’s decision making and behaviour. Recent research has shown that full brain development does not occur until the mid 20s. The prefrontal cortex, the section of the brain responsible for planning, complex problem-solving, weighing up consequences and making judgements, is the final part of the brain to develop. At the same time the area of the brain that seeks pleasure and reward, the nucleus accumbens, is well developed. This means that young people have a heightened need for thrills and excitement, resulting in risky, impulsive choices being made, particularly when these choices have a strong emotional reward such as peer acceptance. This research suggests that after the age of 25, when the prefrontal cortex has matured, people are less likely to participate in high-risk behaviours.

- **greater emotional maturity and a stronger personal identity.** During adolescence young people seek to establish identity and independence. As they clarify their personal beliefs and develop a stronger sense of who they are, young people may feel more comfortable asserting beliefs that are different from **social norms**.

- **greater personal responsibilities.** In adulthood people tend to take on financial responsibilities such as loans, mortgages, rent or car ownership that can change the lifestyle patterns and decisions of young people. They may also become involved in long-term, committed relationships and start their own families, which may bring about changes to their behaviour in relation to things such as tobacco smoking and speeding.

- **different social networks.** The opportunity to mix with a variety of age groups and people from different backgrounds while working or studying may expose young people to different attitudes and values than those held by their peers and communities. This may also contribute to a change in their beliefs.

These various factors, either individually or in combination, may see a person modify their attitudes and their behaviour as they move through adolescence into adulthood.
Genetics may have an influence on a person’s health at any point in their lives, depending on what characteristics or condition has been passed on from the parents. Certain inherited health problems, such as cystic fibrosis, may become apparent early in a child’s development and start having a negative effect on their health. Other health problems linked to genetics, such as breast cancer or schizophrenia, may not have an effect on a person’s health until some point during their adult life, if at all.

Geographic location may be a more significant determinant of health as we become older, especially for those located in rural and remote areas. This is because health services and personnel may need to be used more frequently, however accessing the appropriate services, particularly those involving specialised treatment, may be difficult for those living outside metropolitan regions.

CASE STUDY
Control of the determinants of health
Paul is a year 12 student who lives with his parents on a property in a small rural community in New South Wales. His two older brothers have left home and moved to larger centres to find work. They used to help Paul’s family run the property but several years of drought have meant that the farm is generating little income. The family has been struggling financially as a result. This has placed a great deal of stress and strain on all members of the family.

Last year, Paul’s father had a minor heart attack. The doctors said stress, along with excessive weight and a family history of heart disease, were the reasons for his father’s heart attack.

Paul now helps his father as much as he can on weekends and when he gets home from school. This means he has less time for schoolwork, but he knows his father can’t do it on his own and he feels a strong sense of responsibility to support his family.

Paul has thought about quitting school and working full-time on the property. He has stopped playing football for the school and on weekends so that he has more time available to help. It also helps save money as the cost of travelling to games and paying registration fees was adding to the family’s financial stress.

Since Paul quit football he has put on some weight. He also feels isolated as he rarely gets to spend time with his mates since he quit sport. His parents encourage him to catch up with his friends but Paul feels so tired that he can’t be bothered.

Application
Determining how much control we have over our health
Read the case study above and answer the following questions.
1. Explain the impact of the various determinants on Paul’s health.
2. Identify the determinants impacting on Paul’s health that are:
   (a) modifiable
   (b) non-modifiable.
3. Use your lists from question 2 to assess the degree of control that Paul has over his health.
4. Propose actions that Paul could take that would allow him to gain greater control over his health.
5. Think five years ahead into the future. Discuss whether the determinants are likely to have the same level of influence on Paul’s health. Give reasons for your responses.

2.3 Health as a social construct
It is clear that people’s ability to achieve good health varies according to:
• factors present within their environments, and
• the positive or negative impacts that these factors have on health.
The recognition that individuals do not have complete control over their own health has contributed to an acceptance that health is a social construct. In other words, a person’s health behaviours and health status are significantly determined by factors relating to the social, physical and cultural environment in which they live.

Recognising health as a social construct helps us to explain why some individuals or groups experience better or worse health than others. It also allows us to understand why improving the health status of particular groups within the community can be a complex and prolonged process.

2.3.1 The interrelationship of determinants

Viewing health as a social construct acknowledges that a variety of social, cultural, economic and environmental factors have a significant influence on an individual’s health. It recognises that the impact of these factors on people’s lifestyle and health behaviour does not occur in isolation, but in an interrelated way. The conceptual framework for determinants of health shown in figure 2.28 demonstrates how various socioeconomic, sociocultural and environmental conditions work inwardly to affect the health of individuals and communities.

Evidence showing how various determinants of health relate to and influence other determinants can be seen in the data that is regularly collected on the health status of Australians. These statistics show that groups that commonly suffer poorer levels of health often experience a higher number of negative health determinants in their lives. For example, Aboriginal and Torres Strait Islander peoples, who suffer much more ill health than other Australians, are most likely to:

- be in the most disadvantaged socioeconomic group
- have poorer levels of educational achievement
- have higher rates of unemployment
- work in lower paid occupations, where they experience less secure employment and lower levels of job satisfaction
- live and work in the most hazardous environments where they are exposed to higher levels of risk
- have greater difficulties accessing appropriate health services, resources and support
- have lower rates of home ownership and live in households and communities that have inadequate housing, are overcrowded, have poorer transport and lower levels of social cohesion
- have a lower sense of control, power and opportunity
- have more risk factors for ill health such as smoking, alcohol consumption, obesity and high blood pressure present in their lives.

Understanding the relationship between the various health determinants highlights the difficulties individuals can face trying to exercise control over their own health. It demonstrates the role that governments and communities need to play in addressing the broad range of social, cultural and economic factors that impact on people’s health. It also emphasises the importance of collaborative and targeted approaches being taken by government agencies, non-government organisations and local communities in order to bring about significant and sustainable changes.

**FIGURE 2.28** A framework for the determinants of health

2.3.2 Challenging the notion that health is solely an individual’s responsibility

Health was previously seen as being solely an individual’s responsibility, with each person expected to control and manage their own health by making good choices. Prescribing to this individual view of health meant that poor levels of health were the fault of the individual, through ‘bad’ choices, a lack of motivation, a lack of willpower or a combination of all three. However, this view of health failed to acknowledge that health is socially constructed.

Enjoying a good standard of health is a fundamental right of all Australians. As we have learned, not all the determinants that affect people’s health can be easily modified by individuals to enable them to reach their health potential. This makes health more than just an individual responsibility. Governments and the communities in which we live both have a major responsibility to provide people with the opportunity to achieve the highest standard of health possible.

Bringing about improvements in people’s health requires more than simply informing people of health risks and encouraging them to make better health choices. Having sufficient health knowledge does not mean that a person will automatically choose behaviours that will lead to better health because they know it will be good for them. For individuals to change their health decisions and behaviours, the social and environmental forces that impact on these decisions and behaviours must first change to make good health choices easy to make.

Addressing social, economic and environmental factors that contribute to poor health requires action from all levels of government, along with different community groups. This action needs to involve a range of sectors working together, including health, housing, employment, education and community services. It is only through this type of collective approach that the key social, economic and environmental determinants that affect health are likely to improve. These key principles were first acknowledged and agreed to with the signing of the Ottawa Charter for Health Promotion, which is discussed in topic 3.

**SNAPSHOT**

Understanding what really makes us sick

By Bianca Nogrady

The lifestyle choices you make, such as diet, exercise and smoking, have a huge impact on your health. Yet most of us know nothing of the social factors that drive these.

When it comes to healing the sick, we look to doctors. When it comes to preventing us from getting sick in the first place, many say we should look to governments.

That’s because the vast majority of our biggest killers, such as heart disease, diabetes, cancer, lung disease and mental illness, are significantly affected by where we live, where we work, our income, our education, our socioeconomic status, and our lifestyle.

These are called the ‘social determinants of health’ and leading health experts say they impact on our health more than anything else. This is why governments are encouraged to fund preventive health measures and address social issues that affect our health, as well as funding medical research, hospital beds and GP visits.

Social determinants explain why life expectancy in Japan is double that of Sierra Leone, or why Indigenous Australians have a ten-year lower life expectancy than non-Indigenous Australians.

They explain why some chronic diseases and risk factors such as smoking are more common in rural areas than in urban areas; why changes to the minimum wage can have a dramatic downstream impact on health; why education is as important as health care when it comes to our risk of chronic disease; and why poverty kills.

Wealth determines health

‘In Australia, wealth determines health,’ says Martin Laverty, chair of the Social Determinants of Health Alliance.

‘If you’re in the lowest socioeconomic group, you will die 3.5 years earlier … than the highest socioeconomic group,’ says Laverty, who is also CEO of the Royal Flying Doctor Service.

‘More importantly, if you’re in the lowest socioeconomic group, you will have upwards of three times the amount of avoidable chronic illness than if you’re in the highest group.’
The World Health Organization defines social determinants of health as the conditions in which we are born, grow up, live, work and age, and these ‘are shaped by the distribution of money, power and resources at global, national and local levels’.

These are factors such as income, employment status, access to education, access to health care, access to affordable housing, transport, stress, age, and disability.

‘The common way of defining social determinants of health is in terms of those sort of system things like housing, employment, income,’ says Dr Jennifer May, Clinical Dean of the Peel Clinical School at the University of Newcastle’s Department of Rural Health.

‘The other way that people sometimes define them is those personal social determinants around disempowerment and marginalisation and being part of a disadvantaged group,’ May says.

Impact on risk factors
Social determinants affect your health by impacting on risk factors that can lead to chronic disease and poor health.

‘People who are on lower incomes have higher rates of a whole lot of risk factors, be they tobacco, alcohol, substance abuse, obesity, those sorts of things,’ she says.

‘Poor housing impacts overcrowding, so we see a greater incidence of skin infections and greater impacts of mental health and substance abuse on individuals who live in overcrowded surroundings.’

‘Lack of education, the number of people who finish year 10 for instance, impacts directly on health literacy but also would seem to be related to poorer health outcomes generally, so access to employment, et cetera.’

Not only do individual social determinants affect your health, they also interact and amplify each other.

Understanding poverty’s impact
Take poverty, for example. Associate Professor Lyndall Strazdins says there is no question poverty is bad for your health and in ways you might not always realise. For instance, it often means people can’t buy healthy foods, such as fresh fruit and vegetables. This in turn is associated with increased risk of diseases such as heart disease and some cancers.

‘But one of the reasons people are poor is because they tend to have poor health to start with, so you’ve got a two-way relationship going on there,’ says Strazdins, senior fellow at the National Centre for Epidemiology and Population Health, at the Australian National University.

‘They feed into each other, so if you complicate or compromise people’s health, then they’re less able to be socially productive and participating.’ This in turn means they are less able to work, and so this leads to continued poverty.

Poverty is also associated with increased rates of smoking, alcohol consumption, and drug dependence.

It is also linked to lower educational attainment, which in itself has devastating health consequences. Laverty cites one US study that found not finishing school had a greater impact on the risk of avoidable heart disease deaths than blood pressure, cholesterol and smoking combined.

Another resource that has a huge impact on our health is time. How many of us talk about being ‘time poor’, saying there are not enough hours in the day to shop and cook food, or exercise, or even take time to relax?

This is a very modern malaise that can have significant consequences for your health, Strazdins says.

‘We give the message that you need to go and get fresh food and cook it more, and find time to exercise, without understanding that for some people that’s a very difficult thing for them to do.’

It’s also a resource whose shortage often goes hand-in-hand with poverty. It used to be thought that those who were income poor were time rich, but Strazdins says that idea is increasingly being challenged. In the US, where the minimum wage is lower than in Australia, many people are working full-time jobs on a wage that does not provide enough for individuals and families to live on, giving rise to the class of ‘working poor’.

Living in rural areas
Where we live also has a major impact on our health, and evidence shows that living in remote or isolated settings puts many of us at a significant health disadvantage.

‘There appears to be an additional risk conferred by rurality,’ she says, pointing to data suggesting higher rates of smoking in rural communities, even when compared to disadvantaged urban communities. Indigenous Australians living in rural and remote areas are at an even greater health disadvantage than non-indigenous Australians.

Rural communities also have poorer access to health services. May says this has been linked with higher death rates from cancer.
But not all rural living is bad for your health. There appears to be a kind of ‘sweet spot’ where the disadvantages from rural living are balanced by the advantages of living outside city noise and pollution, and in a smaller, often more connected, community setting.

**Bad place to be**

Being on the bottom rung when it comes to social determinants of health is a bad place to be, and it can be very difficult to climb out of that trap. The solutions are far harder than treating the end results.

‘What happens is we’re all good at the Band-Aid end — the treatment end — and we’re hopeless as a community about prevention, and looking at the social determinants is about prevention,’ May says.

‘How much better would it be if people did have adequate housing and access to education, and they weren’t in the health system?’

But addressing social determinants of health is incredibly challenging because it steps away from health care, and instead requires changes to the fundamental structures of society, Strazdins says.

‘Simply telling people to do more [exercise or healthy eating] is not going to make a difference,’ she says.

‘The feasibility of doing more is driven by something they don’t have as much control over and here you need governments and business and policy all having to come together.’

*Source: ABC Health & Wellbeing, www.abc.net.au/health/features/stories/2015/05/14/4235445.htm.*

---

**Application**

**Impact of social determinants of health**

Read the snapshot ‘Understanding what really makes us sick’. Use the information provided on the role of social determinants to explain why some groups of people have better or worse health than others. Be sure to use specific examples in your explanation to support the points you make.

**Inquiry**

How can the determinants of health explain different levels of health within the community?

1. Listed below are a series of characters. Copy the information about each character onto a separate card and display all these character cards in a straight line in the middle of a whiteboard or sheet of butcher’s paper. Write the words ‘excellent health’ at one end of the whiteboard and ‘very poor health’ at the opposite end.

   - A 35-year-old female with a family history of breast cancer. She works as a doctor in a large inner city hospital.
   - A 26-year-old male refugee from Sudan who has recently received citizenship in Australia. He worked as a farmhand in his home country.
   - An 18-year-old male living at home with his mother and four younger brothers. He left school in year 10 and is currently unemployed.
   - A 50-year-old Aboriginal male who works as a professor at a large university.
   - A 25-year-old female who is a professional triathlete.
   - A 60-year-old farmer running a large cattle property with his two sons. The property is 200 kilometres from the nearest rural town.
   - A 30-year-old Muslim woman. She and her husband run a small business in the metropolitan area. They have three young children.
   - A 40-year-old Aboriginal male living in a remote Indigenous community. He works as a stockman on a nearby cattle property when work is available.
   - A 20-year-old male in his second year of university. His family lives in the country, but he moved to the city to study. He shares a house with three other young people and works part-time to pay his living expenses.

2. Read each of the following statements, then consider which characters would be able to answer ‘yes’ and which characters would answer ‘no’. Every time a character answers ‘yes’, move their character card forward...
on the continuum towards ‘excellent health’. Every time a character would answer ‘no’ move their card back on the continuum towards ‘very poor health’. When unsure, the character card should not move.

- You can afford the cost of private health insurance.
- You have a range of medical facilities easily available to you.
- There are a range of facilities where you can be physically active in your local area.
- You have a support network of family and friends who encourage you to be healthy.
- You are likely to have good knowledge about the benefits of maintaining good health.
- You are able to talk confidently to a medical professional about health concerns and understand information they give you.
- You can afford regular dental checkups and to fix any associated dental problems.
- You are able to access health information and support easily on the internet.
- You are likely to see good health as important and understand strategies that can support or improve your own health.
- You are encouraged to be physically active and you feel confident doing so.

3. When all questions have been considered, examine where the various characters have ended up.

4. Based on the activity, discuss as a class which individuals and groups have better or worse health than others. Explain how the determinants of health are likely to positively or negatively influence the health of various characters.

2.4 Topic review

2.4.1 Summary

- The major factors that influence an individual’s health can be referred to as the determinants of health. These determinants include a number of individual, socioeconomic, sociocultural and environmental factors.
- An individual’s health status can be positively or negatively affected to varying degrees by these determinants acting in various combinations.
- Individual factors that have a significant influence on health include genetics, knowledge and attitudes.
- Sociocultural factors such as family, peers, media, culture and religion can exert an influence on people’s values, attitudes and knowledge about health, which can affect their lifestyle behaviours and health decisions.
- Differences in people’s level of income, education and employment can lead to significant differences in the opportunities, choices and risks that affect their health. Groups in society that experience the greatest disadvantage are likely to experience the poorest levels of health.
- Geographic location can have an impact on a person’s health by affecting their opportunities to make healthy choices, the risks they are exposed to and their access to adequate standards of housing, food and water. It can also influence their ability to quickly and easily access appropriate health care.
- Technology has helped overcome some barriers caused by geographic isolation.
- We may have little or no control over some of these determinants; for example, genetics and some environmental factors.
- Most health determinants are modifiable, that is, people can make changes to some factors that influence them to improve their health status. A person’s level of self-efficacy, empowerment and attitude can contribute to the degree of control they exercise over their health.
- The influence that various determinants can have on our health changes throughout our lifetime. This may lead to improvements in health or may contribute to the health risks people face.
- An individual view of health suggests that the individual is solely responsible for their health behaviour. This has limitations for changing individual motivations and behaviour as it blames the ‘victim’ rather than explaining the social and environmental determinants involved.
• Viewing health as a social construct enables us to recognise the interrelationship between the various
determinants of health, and understand why some individuals and groups have better or worse health
than others.

2.4.2 Questions

Revision
1. ‘People’s social and economic circumstances and environmental factors strongly affect their health.’
   Evaluate this statement. Does it provide a good explanation of how health is determined? (P3) (4 marks)
2. Research has shown that people in the most socioeconomically disadvantaged groups were more likely to
   smoke, eat less fruit and vegetables and be inactive than those in less socioeconomically disadvantaged
   groups. Discuss why these risk behaviours are more likely to be prevalent among people living in poor
   socioeconomic circumstances. (P3, P16) (5 marks)
3. Using relevant examples, explain how sociocultural factors such as family, peers, media, religion and cultural
   background can have a positive or negative influence on a person’s level of health. (P3) (5 marks)
4. Outline how living in geographically remote areas can affect a person’s level of health. (P3) (3 marks)
5. Using relevant examples, discuss the interrelationship of the various determinants of health. Explain the
   possible impact this interaction could have upon people’s ability to effectively manage their own health. (P3,
   P4) (6 marks)
6. Identify aspects of health that an individual is able to exert some control over. Explain how this can be done.
   (P4) (4 marks)
7. A person who is overweight is told by people that it is their own fault because they lack willpower and are too
   lazy to exercise. Challenge these comments by analysing the determinants of health that influence people’s
   activity levels and eating behaviours that are difficult for them to control. (P3, P4) (6 marks)
8. Discuss how and why the determinants of health can explain differences in the health status of two distinctly
   different social groups; for example, people born in Australia and people born overseas; Indigenous and
   non-Indigenous people; people of high and low socioeconomic status. (P3) (6 marks)

Extension
1. Research has shown that a large number of young people with serious mental health problems do not
   access professional help. Analyse how the various determinants of health may impact on the likelihood that
   a young person will access support to help with mental health problems. (8 marks)
2. Australia’s health 2016 found significant differences in the mortality rates of Indigenous and non-Indigenous
   people as shown in figure 2.11. Critically analyse the impact of the various determinants on the health of
   Indigenous Australians to explain the significant gap that is evident between their health and the health of
   non-Indigenous Australians. In your response, highlight how various determinants are interrelated. (8 marks)

Note: For an explanation of the key words used in the revision questions above, see Appendix 2, page 400.

Resources

- Interactivity: Revision quiz: auto-marked version (int-7254)
- Interactivity: Missing word interactive quiz (int-7253)
- Digital doc: Revision quiz (doc-26269)

2.4.3 Key terms

built environment refers to buildings and spaces that are constructed within communities. p. 80
empowerment for individuals means that they are aware of the choices they have, they can make deci-
sions without relying on others or expecting others to make decisions for them and they can act in various
situations in daily life to protect themselves and promote their health. p. 74
environmental factors are those things present in the environment in which people live and work that can
   affect their health in a positive or negative way. p. 79
environmental tobacco smoke is the smoke that comes from the burning end of a cigarette and the smoke exhaled by smokers. It is also referred to as second-hand smoke and passive smoking. p. 85
fluoridated tap water is the controlled addition of fluoride to public drinking water to reduce tooth decay. p. 80
genetics refers to characteristics, features or hereditary diseases that are genetically linked and are passed on within a family. p. 62
health determinants are the individual, socioeconomic, sociocultural and environmental factors that can have a positive or negative influence on the health of individuals or populations. p. 58
individual factors are those factors unique to each person that can determine their level of health. p. 59
inequality is the unequal distribution of illness or conditions throughout the population. p. 88
medicare is Australia’s government-funded health scheme that subsidises the cost of medical services for all Australians. p. 77
modifiable health determinants are those determinants that can be changed or controlled so they have a different level of influence on our health. p. 88
non-modifiable health determinants are determinants that cannot be changed or altered. p. 91
ozone depletion refers to the decline in the ozone layer present in the atmosphere that shields the Earth from harmful levels of ultraviolet radiation. p. 85
remote areas have a population of less than 5000. p. 79
royal Flying Doctor Service provides aeromedical emergency and general health care to people living in rural and remote areas of Australia. p. 81
rural areas are defined by the Australian Bureau of Statistics as having populations between 5000 and 99 000. p. 79
self-efficacy is our belief in our ability to be able to carry out a particular task. p. 61
social construct of health recognises that people have different views of health based on their social circumstances and ways of seeing, interpreting, interrelating and interacting with their environment. p. 99
social exclusion occurs when someone is denied resources, rights and services and is unable to participate in normal relationships and activities that are available to the majority of people in society. p. 77
social gradient in health is a term used to describe the global phenomenon whereby people who are less advantaged in terms of socioeconomic position have worse health (and shorter lives) than those who are more advantaged. p. 73
social norms describe the behaviours, beliefs and values that are expected or seen as acceptable within different social groups. p. 97
sociocultural factors relate to the society in which people live and the cultural practices and expectations that exist within these communities. p. 99