PSYCHOLOGICAL PRACTICE, SOCIAL DETERMINANTS OF HEALTH AND THE PROMOTION OF HUMAN FLOURISHING

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Health inequalities are a persistent feature of our societal landscape. Health inequalities reflect how differences in health outcomes across groups in society are not reducible solely to unhealthy lifestyle choices, individual behaviour, or access to medical care (Hodgetts et al., 2010; McKeown, 1976). People of lower socio-economic status do not get sicker or die more quickly than more affluent groups simply because they do not care about, or know how to look after, themselves and those around them. Substantive evidence supports the conclusion that individual behaviour patterns have a smaller impact on health than socio-economic conditions, which expose some groups to a raft of risk factors while other groups are less affected by such risks (Navarro, 2004; Wilkinson & Pickett, 2009; World Health Organization [WHO], 2012, 2014). Situational factors affecting health at a population level are commonly referred to as social determinants of health (SDH). These include employment patterns and conditions, income, physical hardship, social exclusions, colonialism and racism, violence, educational processes, stigma, food and housing [in]securities, and access to health and social services (National Health Committee, 1998; Hodgetts, Chamberlain, Radley &Hodgetts, 2007; Marmot, 2013; Robson, 2008; Wilkinson & Pickett, 2009). As noted by WHO (2012):

> The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.

Life expectancy and the prevalence of particular diseases among specific social groups are linked to socio-economic gradients. These gradients reflect the ways in which individuals and groups are ranked according to power, processes of colonisation, access to resources, life chances, and social status. Racism and discrimination are particularly important SDH for Māori, as the indigenous people of Aotearoa New Zealand, Pasifika, and other migrant minority groups because these SDH impact on the employment, housing, and educational situations of these groups (*cf.* Robson, 2008).

The higher the socio-economic position of a person the better their health is likely to be and the longer they are likely to live. The reverse is also the case in that the lower the socio-economic position of a person the poorer their health is likely to be and the shorter their life expectancy. The inequitable distribution of resources in society means health is enhanced for more affluent groups and undermined for less affluent groups (Birn, 2009; Hall & Lamont, 2013; Marmot, 2013; Wilkinson & Pickett, 2009). Furthermore, societies with steeper social gradients and larger inequalities are less healthy overall than those with smaller disparities (Wilkinson & Pickett, 2009; WHO, 2013). The impacts of these gradients are also reflected in a range of health statistics including HIV, cancer, suicide, heart disease, and diabetes (Scott et al., 2013). These gradients reflect differing life chances, discrimination, and unequal levels of access to material and psychosocial resources across different groups in society. Raphael (2012), comments on the links between life circumstances and health outcomes and people's socio-economic position:

> These circumstances affect individuals' health through pathways associated with material advantage versus disadvantage, a psychological sense of control versus lack of control, experience of low versus high stress, and adoption of adaptive versus maladaptive coping behaviours. (p. 10)

Recent financial crises have highlighted the intensification of inequities in resource distribution, which are associated with steeper social gradients and increased ill-health (Henley, 2013; Hodgetts, Chamberlain, Groot & Tankel, 2014). The world is now more unequal than it was in the 1920s before the socio-economic upheavals of the 1930s, or indeed any other time in modern history (Credit Suisse, 2013; Pikkety, 2014). This is a major health concern. Yet, it appears that the health of banks, corporations, and economic elites has a higher priority than the health of the majority of the world's people. Trillions of dollars of public money have been diverted upwards to bail out private financial institutions and investors (Ellmers & Hulova 2013). Meanwhile, many countries are engaged in austerity measures that undermine supports, such as public housing and welfare benefits, which have shielded people from the most severe forms of poverty and ill-health (Hall & Lamont, 2013; WHO, 2011). Austerity measures exacerbate the dilemmas faced by people already living stressful and inadequately resourced lives (Boon & Farnsworth, 2011), which are marred by income insecurity, growing debt (Green 2012; Walker, 2011), food insecurity (Dowler & O'Connor 2012), social exclusion (Boon & Farnsworth, 2011), and structural violence (Hodgetts et al., 2014). These life stressors also cause people to become worried, anxious, and to experience a sense of limited control that can have negative impacts on their biological, psychological, and social health (Mikkonen & Raphael, 2010).

Concomitantly, addressing disparities in illness rates and life expectancy requires strategies that reach beyond the auspices of conventional health systems (Mikkonen & Raphael, 2010; WHO, 2014). Although health systems are central to responses to health inequalities, we need to move beyond ". . . the naïve perspective amongst health activists that societal ill-health can be cured by more and better NHS [health] services" (Bambra, Fox & Scott-Samuel, 2005, p. 189). Correspondingly, there are renewed calls for governments, health officials and researchers to return to the *original* intent of the Alma Ata Declaration (WHO, 1978), which advanced a vision of "Health for All". The declaration emphasised the importance of not focusing too narrowly on just solving medical problems and improving health services, but also ensuring the removal of "obstacles to health in wider society". The declaration establishes a basis for advancing a more holistic "health system model" that acts on "the underlying social, economic and political causes of poor health" (Commission on Social Determinants of Health [CSDH], 2008, p.33). Likewise, the WHO (2010, 2012) advocates for a "whole-of-society" approach for addressing SDH.

This chapter adopts a broad relational understanding of health inequalities that embraces an Aristotelian commitment to "human flourishing" (Ruger, 2010. As an aspirational ethical construct, human flourishing underpins the obligation of society to provide the resources and conditions (equitable employment, healthy housing, education, opportunities for civic participation, and social support systems) to enable all people to live healthy lives and to reach their potential (Nussbaum & Sen, 1993). This approach foregrounds how the environments people grow up in and the opportunities to develop and maintain their potential are central to personal and whānau health (*cf.*, Kingi, Durie, Cunningham, Borman & Ellision-Loschmann, 2014). As we will illustrate, secure health requires access to resources and life conditions that allow people to flourish. In Aotearoa New Zealand, we face the sad indictment that increasing numbers of people no longer have access to decent food and housing, secure incomes, and opportunities for civic participation and education (Hodgetts et al., 2014; Mikkonen & Raphael, 2010). Targeted strategies are needed to reverse such developments and to ensure a fairer redistribution of sufficient goods, services, and conditions in life for people to flourish. To advance such changes solidarity and positive relationships within and between social groups needs to be cultivated, which can increase the likelihood of the intergroup transfer of resources (Coote & Angel, 2014; WHO, 2011).

A pertinent question to ask is "why should psychologists involve themselves in advocating for social change to address social determinants of health?" One answer is that SDH are unfair, unnecessary, and preventable; psychologists have an ethical duty to care and to promote human flourishing (*Code of Ethics for Psychologists Working in Aotearoa/New Zealand*). As we will demonstrate in this chapter, community, organisational, clinical, educational, counselling, criminal justice, health psychologists, all have a role to play in supporting human flourishing and addressing health inequalities. We also have obligations from the Treaty of Waitangi to act, because SDH have a disproportionately negative impact on many Māori. Our focus is on exemplifying the situation for tangata whenua. However, the issues discussed in this chapter have applicability to other groups, including Pasifika and precariat Pākehā1 communities, who are positioned lower down the socio-economic gradient, and also experience the negative consequences of SDH.

The following section explores the impact of SDH on Māori and offers insights from Māori understandings

1 The term Pākehā denotes New Zealanders of primarily British and European ancestry.

of health and human life. Section three extends our understanding of actions that can be taken by psychologists to help address SDH. Particular attention is given to interventions targeting the distribution of resources in society, cultivating community supports, and building solidarity between groups in society. The chapter is completed with a brief discussion of key points from previous sections, and an outline for how psychologists can contribute to the resolution of SDH and promote human flourishing.

Health Inequalities: Insights from Māori Understandings of Health

Although New Zealanders are now living longer on average than 30 years ago (Blakely & Simmers, 2011), socio-economic and ethnic differences in life expectancy remain. There is a persistent gap in life expectancy between wealthier (mostly Pākehā) groups and less affluent Māori and Pasifika groups. For instance, from 2010 to 2012 life expectancy at birth for Māori males was 72.8 years and for Māori females it was 76.5 years. This is in contrast to 80.2 years for non-Māori males and 83.7 years for non-Māori females (Statistics New Zealand, 2013). There is a stark 10-year discrepancy between the life expectancy of Māori men and non-Māori women. These differences in life expectancy and associated illness rates reflect our colonial past and the resulting socio-economic divisions that have shaped the living conditions and life chances for socio-cultural groups, such as Māori, over generations (*cf.*, Durie, 2003; Kearns, Moewaka-Barnes & McCreanor, 2009; Whitehead, Povall & Loring, 2014).

Māori are twice as likely to be living in poverty when compared with Pākehā people (New Zealand Treasury, 2012). Māori are the least likely to have completed Level 2 Certificate or higher at school, are twice as likely to be unemployed than non-Māori, and earn much less across the lifespan. Two thirds of Māori live in homes they do not own compared to less than half of non-Māori (Ministry of Health, 2012b). Poverty amongst Māori children is more than double the rate than that of Pākehā children, which means that many of the health inequalities suffered by Māori are cast during childhood. Furthermore, Māori babies are five times more likely than non-Māori to die from sudden infant death syndrome (Blakely & Simmers, 2011). The incidence of Māori youth suicide is also more than twice the rate for non-Māori youth, while self-harm hospitalisations have increased for Māori across all age groups, especially among those who live in the most deprived areas (Ministry of Health, 2012a). For Māori adults, the rate of health loss due to illness and injury is almost twice as high as that for non-Māori, with most of the health loss occurring by or before middle age (Ministry of Health, 2013). Morbidity is an issue for Māori, who are at greater risk of chronic health conditions such as diabetes, heart disease, asthma, skin infections, chronic pain, arthritis, and mental illness. Moreover, when they become sick, Māori adults and children are less likely to have their health needs met compared to non-Māori (Ministry of Health, 2012b).

Media deliberations about Māori health disparities often blame individual Māori for poor outcomes and pay much less attention to the structural inequalities and racism that exist in our society (Rankine et al, 2011; Robson, 2008). The poor state of Māori health is both a personal and institutional issue, and has been directly attributed to the long-term impacts of colonisation (Durie, 2003; Hodgetts, Masters, & Robertson, 2004; Wilson & Baker, 2012). It is recognised that health inequalities lived by Māori today stem from socio-economic hierarchies that have been imposed with colonialism, which results in the personal autonomy and choices for Māori people being limited by their socio-economic positioning (cf., Panelli & Tipa, 2007; Te Puni Kōkiri, 2009).

A focus on SDH, which explains the processes behind differences in illness rates and life expectancy between Māori and non-Māori, is in keeping with the emphasis Māori place on emplaced and relational understandings of health and human/whānau flourishing (Durie, 2003; Kingi et al., 2014). For Māori, health involves the functioning of bodies and minds, but also the quality of relationships between people, places, and economic and spiritual processes (Durie, 1985; Pere, 1991). Health is dependent on both personal and situational elements that have been played out historically, and that manifest in contemporary everyday lifeworlds. Given our colonial history, it should be no surprise that Māori include a focus on both socio-economic and intergroup relations processes in health (Te Puni Kōkiri, 2009).

Pūtahi is a concept that invokes the fundamentally relational nature of all dimensions of life within the universe (cf., Marsden, 2003; Ritchie, 1992). This concept is useful in developing a whole-of-society understanding of, and response to, SDH. The concept provides a larger context for the various aspects of health and illness that can be broken down into smaller components for exploration, while still being seen as elements of much

larger processes (Ritchie, 1992). A whole-of-society approach can be enriched by Māori ways of knowing that emphasise connection and relationships within a large whole. Concepts such as pūtahi inform Māori health models and understandings of people in the physical and social world.

As an early exemplar of Māori models of health, Durie's (1985) Whare Tapa Whā employs the metaphor of the four sides of a traditional Māori meeting house to invoke a holistic understanding. Each side of the house represents one of four interwoven components of health and human flourishing: taha tinana (bodily/physical component), taha wairua (spiritual component), taha whānau (family/social dimension) and taha hinengaro (psychic/mental component). These components are mutually supportive of the entire structure. Each side requires strength and stability, and a solid foundation that anchors it within the environment in order to ensure health. If one side is unstable or compromised, the overall strength and integrity of the building (as a proxy for the person and group) is vulnerable. A key feature of this, and other such models, is the positioning of the physical and socio-economic contexts as central to understanding people's health.

The broad perspective offered by Māori understandings of people and health can help psychologists understand links between societal level processes, local lifeworlds and health outcomes. At the spiritual level, for example, we can see the impact of economic inequalities and associated processes of racism, social exclusion, and stigma in the ways in which circumstances can erode a person's wairua. Such connections between the spiritual and other levels of health are reflected in suicide rates, learned helplessness, and the dissipation of hope in some communities. Damage to the wairua of people can also be transmitted across generations, and in part accounts for ongoing challenges to particular whānau.

The holistic focus in this chapter is important, as it underpins a whole-of-society approach to reducing health inequalities and improving health across a population (*cf.*, WHO, 2010, 2012). Central here is a relational understanding of people in terms of their ongoing connections with other people, history, and the social, material, and economic environments in which they live (Marsden, 2003). People are presented as interdependent beings set in dynamic contexts that shape their very being and health (Marsden, 2003). This is a crucial point, as relational notions of interdependence underpin concepts such as human rights and associated redistributive initiatives, which are designed to address SDH (Raphael, 2012).

Holistic Māori understandings of health reflect how health and human flourishing are determined by a range of interrelated SDH. In the Aotearoa New Zealand context, relational strategies for addressing health inequalities need to consider the colonial legacy, and the associated economic, educational, and health disparities. An example of the application of a holistic whānau-flourishing approach to improve SDH is Whānau Ora (wellbeing of the family/extended family). These types of initiatives respond to the need for building the capacity of whānau by fostering supportive and well-resourced relationships, collective resilience, and community connectedness alongside improved income, employment, housing, food security, and transportation (Te Puni Kōkiri, 2014). Whānau Ora provides a framework for an inter-agency approach to working collaboratively with whānau in navigating the range of health and social services. Whānau Ora responds to the relational practices of family groups that influence their health. Providers of health and social services are mandated to work constructively with whānau across agencies to develop health plans. These plans promote whānau self-determination, sustainability, economic security, healthy lifestyles, increased participation in society and cultural activities, the transmission of traditions, and the cultivation of Māori identities. Primacy is given to strengthening family ties and ensuring adequate material, relational, and cultural resources to enable whānau flourishing (Kingi et al., 2014).

In this section, we have explored the impact of SDH on Māori, associated cultural understandings of health and people, and initiatives to promote whānau flourishing. Māori scholars, practitioners, and communities have provided insightful understandings of people as interconnected beings who rely on quality social relations to achieve health and to flourish. Yet such wisdom is frequently de-emphasised. Our increasingly neoliberal society places more emphasis on self-interest, personal wealth, and competition. This individualised ideology undermines social ties and co-operation and is a threat to population health (Hall & Lamont, 2013). Psychologists need to respond by promoting the benefits of more communal understandings.

In the next section, we explore examples of effective responses to SDH to which psychologists are contributing. These approaches are compatible with the Māori understanding of people, health, and associated initiatives designed to promote social ties, civic participation, and address issues of socio-economic stratification. The perspective offered enhances work from both "materialist" and "psychosocial" approaches to health inequalities (Hodgetts, Chamberlain & Radley, 2007). Combined, these approaches inform our understandings of the

importance of material living conditions, such as being hungry and living in damp cold houses, on people's health. Also important are psychosocial processes associated with the stress, reduced self-esteem, and diminished sense of belonging that comes from SDH, and the associated poverty, racism, and social exclusion.

How Psychologists can Address the SDH

Health psychologists have done important work to foster equitable access to health care and to support people's personal lifestyle changes that promote health (*cf.*, Hodgetts et al., 2010; Lyons & Chamberlain, 2006). In our discipline, the predominant focus tends to be on the health behaviours of individuals. There is also a tendency in psychology to focus on the "immediate" and "visible" health issues of individuals, such as excessive alcohol consumption and smoking (*cf.*, Raphael, 2012). Disparities in health between social groups are often viewed by psychologists as being the product of individual lifestyle choices, unhealthy diets, maladaptive behaviour, and a lack of physical exercise. In advocating for a broader focus that underpins a whole-of-society approach to the SDH, we are not suggesting personal level aspects of health are not important. We are proposing that a primary focus on individual behaviour can obscure structural inequities in society, which constitute foundational causes of health inequalities and barriers to human flourishing (Bambra et al., 2005; Birn, 2009; Hall & Lamont, 2013). Improving the circumstances under which people live, work, and grow is crucial in addressing SDH, and this in effect also reduces the incidence of lifestyle diseases (Hodgetts et al., 2010; Marmot & Wilkinson, 2005). Psychologists need to engage with situational and intergroup relations, the distribution of resources in society, and a raft of factors that are not under the control of individuals facing health inequalities.

A relational-orientated psychology seeks to cultivate social cohesion and solidarity, increase participation, and improve access to resources; it is crucial for human flourishing (Campbell & Jovchelovitch, 2000; Campbell & Murray, 2004; Hodgetts et al., 2010). Psychologists have a long history of promoting meaningful community ties that can buffer people against austerity, promote social inclusion and cultural participation, and build coalitions for social change (Hodgetts et al., 2010; Mikkonen & Raphael, 2010). From the work of Jahoda and colleagues (1993) during the Great Depression, we know that supportive community relationships can buffer people against the effects of deprivation and life stress (*cf.*, Hall & Lamont, 2013; Hodgetts et al., 2010). The work of these early psychologists offers considerable insights into how we can work *with* communities under pressure and respond to societal stress collaboratively.

Relational features of community life can buffer people against the adverse effects of deprivation, although only to a point (Wilkinson & Marmot, 2003). We also need to cultivate a sense of solidarity across communities in order to address the underlying causes of adversity. Addressing the base causes of SDH requires a social contract based on notions of solidarity, empathy, and a sense of responsibility towards others across groups and generations (Coote & Angel, 2014). Such solidarity forms the basis of social inclusion, mutual support, and a willingness to redistribute resources where necessary. Solidarity is anchored in, and grows out of, empathetic, equitable, reciprocal, and trusting social relations, and reduced social gradients. The notion of solidarity was foundational to the advent of modern welfare and social security provisions (Coote & Angel, 2014). Solidarity is based on the assertion that we are all interdependent, and is central to the promotion of human flourishing and the cultivation of a sense of us all "being in it together".

Beyond addressing the immediate needs of the people we work with, psychologists have a role to play in building solidarity by raising wider public awareness about social issues such as the impacts of social inequalities on health. An example of such action can be seen in the 2014 TVNZ documentary series on social issues including social inequalities, education, alcohol, the prison system, and child abuse (McNeill, 2014). These documentaries were fronted by a clinical psychologist, Nigel Latta. The overall objective of these programmes was to increase social awareness and solidarity. They exemplify the potential for clinical and community psychologists to work with communities and the broader public to cultivate shared understandings of the structural causes of mental distress, unhealthy behaviours, and physical illness. Psychologists can help to build communities that cope better, while also working to address income gaps. We can network with other health, policy, legal and media professions, and service providers to ensure that we have a safer and more health-enhancing society where people do not fall through the cracks between services and support systems.

The assertion that "context", and in particular interpersonal and intergroup relationships matter for people's health, is not new (Hodgetts et al., 2010). It is evident in the work of leading social and community psychologists to address SDH such as racism, the criminalisation of families in need, and violence. As a profession, we have

access to decision-makers. We need to work to ensure that we have input into policies and institutional processes that shape people's health. For example, Professor James Liu and colleagues have worked extensively with the Human Rights Commission to document the impacts of racism on minority groups, to advise on related public policies, and to support public awareness of diversity. Liu and colleagues also work to build closer ties between the Commission and various stakeholders, most prominent among which have been the New Zealand Federation of Multicultural Councils and the Office of Ethnic Affairs. Similarly, Professor Darrin Hodgetts and colleagues conduct professional development workshops with judges through the Institute of Justice. The objective is to inform sentencing practices with insights from the lived realities of defendants from lower socio-economic status groups, and to demonstrate how a person's criminal activity often results from inadequate access to resources for feeding and housing their family (Hodgetts et al., 2013).

In the field of violence, Professor Mandy Morgan, Dr Leigh Coombes, Dr Neville Robertson and colleagues have worked to develop policies and legal frameworks to enhance service provision and address the causes and implications of violence as a SDH. These psychologists have worked with service providers, policy-makers, police, lawyers, the courts, social workers, and health professionals to develop more coordinated and humane responses to domestic violence, in particular. Their work targets the interactions between those caught up in violent relationships and the wider family, community, institutional and societal settings in which they are embedded. The ultimate aim is to promote violence-free communities in which families can flourish.

Taking a complementary community focus, Nikki Harré (2011, 2013) has made a considerable contribution to the psychology of sustainability and the environmental movement in Aotearoa New Zealand. Nikki has worked to challenge the individualism championed by neoliberalism and to cultivate more collectivist values as a basis for developing a healthier society. Her work is focused on environmental sustainability and collective health. Nikki's political activities have involved developing an approach to political activism designed to foster civic participation, human connection, cooperation, and a more equitable society. Harré's (2011) self-published book (which can be downloaded for free) shares strategies for inspiring co-operation and sustainability, and for fostering the foundational human motive towards co-operation and the common good (see for example www.infinite-game.net).

Public health literature has shown well-documented evidence that people's housing situations have a significant bearing on their4152 health, and therefore housing is a key issue for addressing place-based SDH. In Aotearoa New Zealand, there is an urgent need to improve the housing stock so that people have better access to more affordable houses that are fit for human habitation. People living in over-crowded and sub-standard housing are more likely to experience poor mental and physical health. People living in over-crowded homes also have increased likelihood of contracting skin infections or intestinal diseases like diarrhoea and fever (Howden-Chapman & Wilson, 2000; Ministry of Health, 1999). Lower socio-economic status people tend not to own their own homes and many rental properties in Aotearoa New Zealand are of a low standard. Consequently, introducing a warrant of fitness for rental properties has been recommended. Work on addressing SDH through housing has been led by a clinical psychologist who works as a public health practitioner (Howden-Chapman et al., 2007). A team led by Philippa Howden-Chapman has documented the positive health impacts of initiatives such as insulating homes in addressing issues such as asthma and psychological distress. Practical initiatives, such as home insulation, that focus on improving everyday living conditions reflect aspects of holistic Māori health paradigms (Durie, 1985: McNeil, 2009; Penehira, Smith, Green & Aspin, 2011; Pere, 1982, 1991). A patient's respiratory problems, for example, may not be solved in the long term by continually prescribing antibiotics or inhalers. Such a reactive approach seems fairly pointless if asthma sufferers live in poorly constructed, cold, uninsulated houses, with high levels of mould (Howden-Chapman et al., 2007). It is important that we place such health initiatives in the context of broader upstream, structural- or societal- orientated efforts that shape relationships in local settings. Working locally, we can address SDH by improving general living conditions (Whitehead, Povall & Loring, 2014).

Moving further upstream, human flourishing and health needs to be resourced by assisting all people in a society to realise health-enhancing and secure lifeworlds. To achieve such aims initiatives need to involve:

> Reducing levels of educational failure, reducing insecurity and unemployment and improving housing standards. Societies that enable all citizens to play a full and useful role in the social, economic and cultural life of their society will be healthier than those where people face insecurity, exclusion and deprivation. (Wilkinson & Marmot, 2003, p. 11)

Correspondingly, collective-action approaches to health are essential to address the economic, environmental, and social factors associated with illness (Beaglehole, Bonita, Horton, Adams, McKee, 2004; Eng & Blanchard, 2007).

Redistributive taxation systems, public housing, welfare benefits, labour reforms, and universal access to health care have proven to be key levers for improving the overall health of groups bearing the brunt of the SDH (Bhatia & Rifkin, 2010; CSDH, 2008; British Academy, 2014). Scott and colleagues (2013, p. 6) note that "Elimination and prevention of inequalities in all-cause mortality will only be achieved if the underlying differences in income, wealth and power across society are reduced". The effectiveness of such efforts becomes apparent when we look at history. The greatest improvements in morbidity and mortality rates in the industrialised world occurred during the 1800s and 1900s, and resulted from increased safety requirements for work and home, sanitation, child labour reforms, protection for workers, and the distribution of vaccines throughout the population (Hofrichter, 2003). In many developed nations, further improvements were made in health following the post-World War II investments in social services and infrastructure (Wilkinson & Marmot, 2003).

To achieve better health for all, we also need to shift away from economic models based solely on individual interest and the profit motive, since these models are corrosive for human flourishing and take no account of the interconnectedness of human existence (Sen, 1999). As Wilkinson and Marmot (2003) state:

> Through policies on taxes, benefits, employment, education, economic management, and many other areas of activity, no government can avoid having a major impact on the distribution of income. The indisputable evidence of the effects of such policies on rates of death and disease imposes a public duty to eliminate absolute poverty and reduce material inequalities. (p. 17)

According to these authors a healthier society is one where all people are able to access quality services; minimum income guarantees and liveable wages; affordable, warm and dry housing; reduced social stratification; and increased equity and fairness across social groups. Income is one of the primary social determinants of health since the:

> Level of income shapes overall living conditions, affects psychological functioning, and influences health-related behaviours such as quality of diet, extent of physical activity, tobacco use, and excessive alcohol use. (Mikkonen & Raphael, 2010, p. 12)

Organisational psychologists, such as Professor Stuart Carr and colleagues (2014), have advocated structural interventions, including the introduction of a living wage, as a means of addressing issues of wellness, equity, dignity, empowerment, and quality of life. The concept of a living wage has been evident since the 19th century and is defined by the minimum hourly amount needed for workers to survive and participate as active citizens in society. The *Living Wage Aotearoa* New Zealand campaign was launched in 2012, amid concern about the fact that over the past 30 years Aotearoa has gone from one of the most equal countries in the developed world to one of the most unequal. Psychologists such as Charles Waldegrave have been centrally involved in the campaign and have determined that in 2015 the living wage is $19.25 per hour, which includes taxes and transfers (King & Waldegrave 2014; Living Wage Aotearoa New Zealand, 2015). Such interventions also support human capacity development and flourishing, can lift many people out of "poverty traps", lift productivity and reduce absenteeism (Carr, 2013; Carr, Arrowsmith & Watters, 2014; Pickett, 2014).

Given that Māori, Pasifika and poorer Pākehā people are much more likely to be working in minimum wage jobs, the introduction of a living wage will have a disproportionately positive impact on these workers. A further justification for the living wage is that low wages not only affect individual workers and their immediate families, but threaten the viability of whole communities. The "costs" of low wages are borne out in poor health and education outcomes, constrained local business, reduced social cohesion, and escalating social spending, putting further demands on taxpayers. A key unifying principle of initiatives such as the living wage is that a decent income is a basic human right. A living wage should be sufficient so that the lowest paid workers in a society are not facing severe financial stress and impossible "choices", such as having to choose between paying for food or for heating (Living Wage Aotearoa New Zealand, 2014).

Successfully addressing SDH and the resulting health inequalities requires a combination of universal initiatives, such as the introduction of a living wage, as well as targeted initiatives, such as the government's

Whānau Ora initiative and the Working for Families package. As Whitehead, Povall and Loring (2014, p. 15) write, "One of the key principles of reducing health inequalities is that we should try to level up the health of those that are worst off to that of the better off, which means improving their health faster than those who already have better health". Cash transfer interventions (WHO, 2011), such as Working for Families, which are designed to lift families out of poverty, are important for addressing the health needs of people negatively affected by socio-economic gradients and associated SDH.

Working for Families was introduced in 2004 by the fifth Labour-led government and provides income top-ups for families whose paid employment does not provide adequate income for them to flourish. The programme targets low to medium-income families in paid employment. It excludes unemployed families who rely on welfare benefits, yet these families are arguably in greater need of such income top-ups (St John & Dale, 2012). Susan St John and colleagues from the Child Poverty Action Group (CPAG) have challenged the government through the courts in an effort to have the Working for Families initiative extended to unemployed households (St John & Dale, 2012). CPAG argue that the children of unemployed families are being unfairly discriminated against in order to control government expenditure. They propose that society will end up paying for the health problems resulting from these children not being lifted out of poverty. Several psychologists are supporting the efforts of CPAG and have involved themselves in such political struggles to address child poverty.

In sum, psychologists have been involved in successful initiatives to address the negative consequences (and inequalities) of SDH. These include strengthening individuals' knowledge and capacity to act to preserve their health, strengthening communities, improving access to essential services, and encouraging macro-economic and societal changes that redistribute resources in society from those with the most to those in need (Birn, 2009). Whitehead, Povall and Loring (2014) identify three priorities for such initiatives, which we see as directly relevant to the practice of psychologists in Aotearoa New Zealand. First, there is a need to adopt a life-course orientation targeting the needs of children as early development has a major influence on health throughout life. Second, there is a need to improve the living conditions of groups experiencing health inequalities. The third priority is to develop and/or maintain equitable social and health protection systems, including recognising the political dimensions of health. For example, the secretive negotiations around the Trans-Pacific Partnership Agreement (TPPA) are prioritising the profits of multinational corporations and investors over national sovereignty and public good in healthcare (Gleeson & Friel, 2013; Löfgren, 2011). A primary objective of such trade agreements is to reduce the ability of governments to advance public health objectives such as providing access to low-cost medications, and to regulate products that have been shown to be harmful to health, including tobacco and alcohol (Gleeson, Lopert & Reid, 2013; O'Brien and Gleeson, 2013).

Conclusion

Issues of power, inclusion and the quality of social relations are critical determinants of the health of a population. Adversarial societies, in which people care more for themselves than others, are less conducive to health. Conversely, in more egalitarian societies people know they can count on the support of others when dealing with adversity and in attempts to maintain their health (Wilkinson & Pickett, 2009). Psychologists have a role to play in building a more equitable society as well as ameliorating some of the consequences of social inequalities and stratification through initiatives targeting individuals, whānau, and communities. We also need to extend our efforts beyond initiatives targeting unhealthy behaviours and initiatives to ensure access to appropriate health services. Such efforts are important, but the promotion of human flourishing requires us to support changes to the features of society, such as social gradients, which cause health inequalities. To contribute to such work, practising psychologists need to look beyond the local context, and resist our disciplinary tendency to fixate on "local" problems, while ignoring their structural causes. This approach requires a level of reflexive practice that moves beyond the individuals concerned to consider the intergroup contexts in which our clients are embedded, and how some are privileged and others disadvantaged through wider societal processes. In doing so, we need to think past artificial distinctions between the economic, psychological, community, health, and societal domains, since all of these domains are interrelated. We must consider the role of society in shaping the health of people with whom we practice. We also need to consider our own actions and societal positioning, to ensure that our actions do not perpetuate social inequalities and the SDH. Rather than solely helping individuals and groups to cope with adversity, we must also work to remove the adversity and risks to health that have a wider societal aetiology.

Psychologists can do more to address the inequalities in terms of resources and health status, which are due in

most part to unjust societal structures (Marks, 2008). To act on such injustice involves developing strategies for challenging social inequalities and efforts to build consciousness around the political nature of health (Parker, 2007). This is a practical initiative because as Bambra and colleagues (2005) argue ". . . an awareness of the political nature of health will lead to a more effective health promotion strategy and more evidence-based health promotion practice" (p. 1). Psychologists can do more to document, understand and respond to the ways in which social contexts, processes such as colonisation, and the distribution of resources and power in society damage the health of particular groups. Reflecting the early work of collectivist orientated social psychologists (Jahoda et al., 1933), Campbell and Murray (2004) propose that an effective approach to health in psychology must highlight and contest power imbalances in society and processes that lead to health inequalities. We cannot simply focus on helping people to pick up the pieces of their arduous lives. Through our research and practice, we can promote broader and more humane understandings of poverty and the health consequences of social gradients and associated injustices. Although psychology often stands accused of being an overly problem-focused discipline, we are fortunate to have many positive and practical examples to work from. In this chapter, we have shown that as psychologists we can offer our skills in working with other professions to address issues of income, housing, social participation and violence that constitute SDH, and that drive inequalities in our society today.

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SOCIAL JUSTICE AND COMMUNITY CHANGE

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This chapter questions how psychology, as a discipline, can practise resistance to Western cultural imperialism in order to open up spaces that facilitate the practice of psychology in diverse socially just ways. We engage our legal (Health Practitioners Competence Assurance (HPCA) Act (2003) and ethical (*Code of Ethics for Psychologists Working in Aotearoa/New Zealand* (2002) (Code of Ethics) requirements for competence and accountability in our disciplinary research and practice. Through an ongoing process of wānanga (discussion and learning), this chapter reflects our commitment to developing a responsive teaching curriculum (at 300 level) that critically evaluates, and reflects on, valuing cultural and social diversity as it applies to the discipline of psychology. When we teach issues of diversity, we also need to attend to marginality by engaging a reflexive dialogue to interrogate our participation in psychological knowledge production as a form of ethical activism. Such reflection demands an ethical commitment to Te Tiriti o Waitangi and the Code of Ethics. This chapter, therefore, addresses specific competencies for working as a psychologist in our location as teachers, researchers, and practitioners within a context where the tensions between globalisation and locality specify 'our' place in the economy of knowledge production. We pay particular attention to the way in which psychology, as a disciplinary community, opens its boundaries to "bicultural research, partnership research, and multidisciplinary research" (Smith, 1999, p. 17) consistent with the aim of *transforming* social and cultural justice (Institute of Community Psychology Aotearoa, n.d., para. 3).

Social justice and responsibility to society, according to the Code of Ethics, are based on principles that require us to attend to social power relationships. We are responsible for our participation in relationships with people in their communities and in the broader context. Vital to the advancement of social justice is respect for the dignity of people in their diversity and through their difference. Specifically, this principle asks us to "embody explicit and mutual expectations of integrity" as an ethical relationship to biculturalism, and to take responsibility for the practice of care for the *structural* and *cultural* practices that bind specific communities. An ethical regard for care includes the responsibility for the production of psychological knowledge for the benefit and welfare of our society, including our participation in *social* and *political systems*. As community psychologists, we understand the principles that guide ethical practice as an opportunity to benefit members of society and to do no harm in the pursuit of social justice.

This chapter engages Arrigo's (2013) 'Society of Captives' thesis as a critical framework for recognising and reflecting on our position as the face(s) of teaching, research, and practice. This provides us with a way to specify our place in the economy of knowledge production and to reflect on how our participation is made possible through the production and normalisation of technologies that legitimate authority over 'normalcy' through the commodification of 'risk' (of difference). In other words, we interrogate our relationship with the power to authenticate 'legitimate' boundaries between ourselves and what we do, and the lived material effects of a knowledge economy where the discipline of psychology is an active participant in developing and maintaining structural and cultural practices that inscribe meaning on the body of the other. For example, when we use our knowledge to produce an individual through a diagnostic category such as borderline personality disorder, it has the potential to inscribe meaning onto the other: "I'm borderline, I'm treatment resistant, I'm difficult . . . I'm lazy, and I don't try hard enough" (Johnson, 2013, p. 669). In this way, we limit the experience and the potentials for being and relating. We suggest that for it to be possible to transform social injustice, our ethical competencies necessitate negotiating meaning.

Reflecting on Our Own Location

We examine how psychology engages with systems of categorisation and normalisation that reproduce a