



# Promoting equity in healthy eating

An evidence summary

FAIR FOUNDATIONS HEALTH EQUITY SERIES



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# Introduction

## Background

Unhealthy diets are responsible for a significant proportion of Australia's chronic disease burden. The prevention of obesity and diet-related chronic diseases is a national priority, and there has been considerable investment in efforts to promote healthy diets in recent years. The overwhelming focus of this investment has been on individual-level factors influencing diets, such as nutrition-related knowledge, attitudes and behaviours.

Actions at this level tend to be the least politically sensitive and the easiest to evaluate for impact. However, they also tend most to benefit those with minimal social, physical and economic barriers. Alone, therefore, they have limited potential to address the steep social gradient in diet quality and associated health outcomes in Australia, whereby diets progressively improve with increasing social position. At worst, there is significant potential for poorly planned healthy eating interventions to worsen, rather than improve, the social gradient.

The social gradient in diet quality and associated health outcomes in Australia can be measured across a range of indicators of social position. Higher income groups, non-Indigenous Australians and people living in more advantaged neighbourhoods are more likely to eat a healthy and balanced diet, be a healthy weight and have better health outcomes. Conversely, Indigenous Australians, minority cultural groups, people living with disabilities and people living in remote and/or socioeconomically disadvantaged areas are more likely to be food insecure (have limited or uncertain availability of, or ability to acquire, affordable nutritious, safe, and socially and culturally appropriate foods), more likely to be overweight or obese, more likely to have poor oral health, more likely to develop cardiovascular disease or type 2 diabetes in their lifetime, and more likely to die from a lifestyle-related chronic disease.

Indigenous Australians experience the greatest impact from diet-related illnesses, with higher rates of overweight and obesity, cardiovascular disease, type 2 diabetes, chronic kidney disease, dental decay and dementia than other Australians. Age-adjusted prevalence rates of diabetes, for example, are three times higher among Indigenous than non-Indigenous Australians.

The existence of these systematic inequities in access to, and consumption of, a healthy diet in a food-rich country such as Australia is both unnecessary and unjust.

Health equity is the notion that all people should have a fair opportunity to attain their full health potential, and that no one should be disadvantaged from achieving this potential if it can be avoided.

Health inequities are differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair.

The social determinants of health inequities are the social determinants of health – or the health-influencing social conditions in which people are born, grow, live, work, play and age – and the social processes that distribute these conditions unequally in society.



[www.vichealth.vic.gov.au/fairfoundations](http://www.vichealth.vic.gov.au/fairfoundations)

## Using this document

This evidence summary is intended to provide policy makers and practitioners in Victoria and across Australia with practical, evidence-based guidance on promoting equity in healthy eating. It is designed to be used alongside 'Fair Foundations: The VicHealth framework for health equity' [www.vichealth.vic.gov.au/fairfoundations](http://www.vichealth.vic.gov.au/fairfoundations) – a planning tool developed and published by VicHealth in 2013 to stimulate and guide action on the social determinants of health inequities.

Health inequities are differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair. In Victoria and across Australia, health outcomes progressively improve with increasing social position. This is known as the social gradient in health. Key markers of social position include socioeconomic status, gender, race/ethnicity, disability, aboriginality and neighbourhood characteristics. The underlying social structures and processes that systematically drive this social hierarchy, and in turn determine individual exposure and vulnerability to a range of everyday living conditions that can be protective of or damaging to health, are known as the 'social determinants of health inequities'.

Common underlying drivers and determinants of health inequities are outlined in the Fair Foundations framework. This evidence summary is one of eight that use the framework to examine a specific health issue and its determinants (mental wellbeing, healthy eating, physical activity, alcohol, and tobacco use), or specific opportunities for action (through social innovation, settings-based approaches, or a focus on early childhood intervention as an upstream solution to health inequities over the life course). In many cases, the key social determinants of health inequities (such as education or employment) are also discussed as settings for action (e.g. schools, workplaces) within each summary.

This summary focuses on interventions that have successfully impacted on, or that have significant potential to address, diet-related inequities if designed and targeted appropriately. It highlights best practice and priorities for action across all three layers of the Fair Foundations framework – Socioeconomic, political and cultural context; Daily living conditions; and Individual health-related factors – in order to support coordinated, multisectoral approaches.

# What can be done to promote equity in healthy eating?

Addressing inequities relating to food and diet demands an inherently political approach, founded on cooperation and joint accountability across multiple sectors and levels of government, and simultaneously engaging the responsibility of the state while promoting social participation and empowerment. Actions are needed to address the underlying social structures and processes that systematically and unequally distribute the determinants of unhealthy eating in society, as well as the environments in which people make their everyday food choices, and the individual health-related factors that result from, and are responses to, this broader context.

## Socioeconomic, political and cultural context

The purpose of intervening at this level is to reshape fundamental and often deeply ingrained social, economic, political and cultural systems, processes and norms. Actions targeting this level are therefore, unsurprisingly, likely to be the most politically sensitive and difficult to implement and evaluate; however, they are also likely to have the greatest and most sustainable impact on inequities in healthy eating.

## Governance

Food governance can be broadly defined as the mix of regulatory and non-regulatory structures, institutions, mechanisms, rules, norms and practices at the global, national and local levels that set limits and provide incentives for individuals and organisations in the production, distribution, promotion, procurement and consumption of foods. It is a highly complex and often-disputed concept that encompasses the needs, interests and priorities of, as well as interactions between, multiple public and private actors. This includes a wide range of social, economic and political structures, institutions and decision-making processes from the health, agriculture, environment, education, social-services, trade, finance, and planning sectors that can influence the ability of different social groups to access and eat a healthy diet.

A key equity concern relating to food governance is the extent to which decision-making processes within each of these sectors represent the needs and interests of different groups as they pertain to food. In general, approaches to food governance – both in Australia and internationally – have undergone a fundamental shift in recent decades, away from state control towards greater engagement of, and increasing responsibilities for, food-industry actors and ‘enabled’ consumers. However, the concept of ‘enabled’ consumers is highly problematic, with consistent evidence demonstrating that the paradigm shift in food governance towards greater commercial and individual responsibility has most benefited the diets of more advantaged social groups.

There is a limited evaluation evidence base for actions to promote equity in healthy eating that have explicitly targeted governance issues. Mechanisms designed to balance the interests of powerful commercial groups, to safeguard the independence of regulatory authorities, to foster the participation of less advantaged social groups and to ensure transparency in all decision-making processes are essential components of a health-promoting and equitable food system. Health promotion professionals and civil-society movements can play an important role in advocating for these mechanisms, and holding both government and industry to account.

## Policy

Policies aimed at any aspect of the food system, including agriculture, manufacturing, trade, planning, fiscal and consumer-protection policies, can directly or indirectly influence diets by shaping the relative physical accessibility, nutritional quality, price and acceptability of different foods available in different settings. In addition, a broad range of fiscal, labour, social-welfare, land and housing, education, health, transport, and other macroeconomic and social policies can affect households’ ability to access and afford a healthy diet.

Policies with the potential to influence the social gradient in healthy eating can be broadly categorised into nutrition-specific and nutrition-sensitive measures. Nutrition-specific policy measures aim directly to influence the food supply. They include economic instruments aimed at changing the relative price of different foods (through taxes, tariffs, subsidies or other measures), regulatory and legislative controls (including controls over the marketing, labelling and composition of foods), and food-relief schemes targeted at high-risk or disadvantaged groups.

Nutrition-sensitive policies are typically implemented outside the health and food sectors, and may not necessarily explicitly acknowledge or seek to address healthy eating. However, they can have a significant impact on inequities in dietary behaviours and associated health outcomes by shaping the nature, extent and distribution of social stratification.

### **Nutrition-specific economic instruments**

The cost of fruits, vegetables and other healthy foods in Australia has been rising faster than the cost of less nutritious foods and the Consumer Price Index. There is strong evidence that food prices, and the relative prices of different foods, influence consumption. Taxes (or additional taxes) on specific foods or food groups aimed at disincentivising their consumption (so-called 'health taxes' or 'fat taxes') have the potential to be a highly cost-effective strategy for shifting population diets in a healthier direction. Cost is usually the most important factor determining the food-purchasing decisions of lower-income households. Therefore, taxes can be financially regressive if they place a disproportionate burden on those who are socioeconomically disadvantaged. At the same time, they can have the greatest impact on lowest-income shoppers who spend a greater share of their income on food and tend to be more price sensitive.

Healthy-food subsidies may be more beneficial for people on lower incomes, although there is the potential that they will be accompanied by undesired increases in purchases of foods high in fat, salt and sugar. Policy packages of taxes on unhealthy foods, in combination with subsidies for healthy foods, are considered to offer the greatest potential from a health equity perspective. They would ideally be implemented as part of a multistrategy approach encompassing stronger food-labelling and reformulation policies, advertising restrictions and a focused, sustained public awareness campaign.

### **Regulation of food marketing**

Internationally, marketing of unhealthy food and beverages is now widely recognised to have sufficient negative influence on food preferences, purchases and dietary intake to warrant preventive action, as recognised in the World Health Organization's set of recommendations on the marketing of foods and non-alcoholic beverages to children. From an equity perspective, population-wide controls on food marketing through mass media and in public settings where people (and in particular children) spend a large amount of time (such as schools, shopping malls and sports clubs) are likely to have positive impacts across the social hierarchy. However, with few real-world examples of statutory regulation of food marketing to children, there is limited empirical evidence of the size of the impact. Ideally, restrictions would be implemented across all dominant forms of media, including outdoor advertising, the internet and sports sponsorship, in order to avoid the shifting of advertising to new media (e.g. internet, social media).

### **Food labelling**

Mandatory regulation of certain aspects of food labelling is widely accepted as an important tool for aiding informed food-purchasing decisions, with some evidence that this can track through to behaviour change. Food labelling also has the potential for additional benefits in the form of product reformulation as companies try to improve the nutritional profile of products in response to stricter labelling standards. However, understanding and use of nutrition labels tends to be considerably lower among lower-income, less educated groups. There is therefore a need for improved understanding of barriers to their use and understanding in population groups most at risk of unhealthy diets. There is also a need for interpretive, easy-to-understand, front-of-pack labelling systems, such as the new voluntary Health Star Rating labelling system in Australia, with ongoing monitoring of effectiveness in different social groups and complementary strategies implemented to enhance effectiveness within disadvantaged groups.

### Food composition

Interventions aimed at reducing the proportion and amount of less healthy nutrients in processed food products can be achieved through legislation (such as bans on the use of industrially produced trans fats) or through voluntary collaboration between industry, governments and/or non-government bodies (as seen in the UK Responsibility Deal, the Australian Food and Health Dialogue and the Australian Heart Foundation Tick Program). Reducing salt and eliminating trans fats from the food supply are widely considered to be ‘best buys’ for diet-related non-communicable disease prevention and control. The strongest evidence is for the impact and cost-effectiveness of government-led food reformulation initiatives; however, to date, most actions have involved voluntary industry commitments.

### Food-relief schemes

Targeted food- and financial-assistance strategies offer potential to support low-income or otherwise disadvantaged households to access healthier diets. However, there is limited high-quality evidence of the impacts or cost-effectiveness of these strategies on healthy eating. Providing food vouchers rather than direct cash payments may help to ensure that food is readily available to disadvantaged households and to reduce potential for compensatory spending, but targeted food subsidies alone may not be efficient without additional policy instruments.

### Nutrition-sensitive policy measures

A wide range of social and economic policies and actions can indirectly help to reduce diet inequities by improving living and working conditions (including providing paid parental leave and flexible working hours), increasing access to education, challenging harmful gender norms, promoting a rights-enhancing legal environment, promoting healthy local food environments (e.g. through nutrition-sensitive trade and planning policies), and providing stronger income and social protection. However, they have rarely explicitly sought to improve, or been evaluated for their impact on, diets.

### Cultural and societal norms and values

Cultural and societal norms and values may be as, or more, important in shaping diet quality and the social distribution of healthy eating behaviours as the physical availability and price of foods. Social and cultural norms around meal times, occasions and rituals, for example, play a critical role in shaping the acceptability and desirability of different foods and eating patterns, as do gender norms around food shopping, cooking and food allocation within families and households, openness to new foods, the valuing of thrift or displays of wealth and status in food purchasing, and the social acceptability (or desirability) of body fat.

While many of these norms have evolved over long periods of time out of social, cultural and religious systems, food-industry actors are playing an increasingly influential role in shaping them. This is most visible through the influence of advertising in shaping food preferences – particularly those of children and young people, who are overwhelmingly exposed to marketing of energy-dense, nutrient-poor foods and beverages, and are uniquely vulnerable to the persuasive power of marketing messages. Food advertising is widely acknowledged to be an important driver of food preferences and purchasing behaviours, shaping the types of foods and dietary patterns that are acceptable and desirable in different social groups.

Socially disadvantaged children may have greater exposure to food marketing, both inside the home (e.g. through greater screen time) and in the neighbourhood in which they live. They may also be more vulnerable to the persuasive power of marketing messages, particularly those involving competitions (such as ‘free toy with purchase’ promotions).

While public awareness campaigns are generally considered to act at the individual level, by influencing knowledge, awareness and behaviours, they can also play a role in shaping broader cultural and social norms and values, as well as public opinion and public policy over the long term. Nutrition-sensitive awareness-raising campaigns addressing a wide range of issues – including gender norms, social exclusion and community values around minimum wages, social support and safety nets for low-income groups – have the potential to complement and support more nutrition-specific actions, and influence the degree to which these are prioritised politically.



## Daily living conditions

### Early childhood and education

#### Early childhood as a critical life stage

Pre-pregnancy, pregnancy, the antenatal period and early childhood are critical periods for promoting and supporting healthy diets. The effects of nutritional advantage or disadvantage experienced early in life can compound over the life course, shaping basic learning, school success, economic participation and social citizenry. They can also have intergenerational effects.

Empowering parents and other caregivers to choose healthy foods means ensuring enough money and time to do so. This requires family-friendly social-protection policies that guarantee adequate income and maternity benefits, and allow parents to balance their time spent at home and work. Measures to improve access to, and acceptability of, prenatal and antenatal care programs for socially disadvantaged mothers can include making transport support, home visits and telephone support available, providing flexibility in times, deploying multicultural health workers and providing educational materials in multiple languages.

#### The learning environment as a setting for healthy eating interventions

Early childhood centres and schools can be important settings for encouraging healthy eating and exposing children to new, healthy foods. Education also plays an indirect role in shaping dietary behaviours by equipping children with the skills and resources needed to go on to achieve secure employment and income, and to develop the resilience that enables people to cope with life experiences, all of which play a role in diet quality.

Schools have received more attention than any other institutional context as a promising setting for the promotion of healthy eating. Commonly used strategies include the integration of nutrition education and skill-building programs into school curricula, the provision of free or subsidised healthy foods/meals to students, the removal of unhealthy foods from school environments (including canteens and vending machines, as well as nearby food retail outlets) and initiatives to increase the availability of healthier options.

Well-planned school-based interventions can improve knowledge and awareness, and can have modest, positive impacts on eating behaviours, including willingness to taste new healthy foods, at least in the short term and within the school environment. There is less evidence that improved eating behaviours at school extend to eating behaviours in the home or other settings outside school, or over the life course. Multicomponent, whole-of-school interventions incorporating supportive school policies, and promoting parental and family involvement, appear to be more effective than single-strategy interventions.

Pre-existing knowledge, attitudes and habits can have a strong mediating influence on the effectiveness of school-based interventions in different social groups. This reinforces the need to account for social and cultural variations in food preferences, to address healthy food accessibility and affordability in the multiple settings in which children spend their everyday lives, and to reinforce school-based interventions with wider community and population-level strategies.

### Employment and working conditions

Employment and working conditions – including wages, job security, working hours, and levels of flexibility and control – are powerful social determinants of diet quality. Income directly determines the amount of money an individual or household has available to spend on food, and is one of the key determinants of dietary choice among low-income groups. Many Australian families and households that operate on low incomes or are dependent on welfare report that they experience difficulty in affording a healthy diet.

The types, quality and cultural acceptability of foods available in the workplace, as well as the challenges of managing the time available for meal planning, food shopping and meal preparation, can also impact on diet quality. Work-related sources of stress, fatigue and dissatisfaction, including poor work–life balance, can diminish diet quality indirectly through their influence over perceived self-efficacy and control, happiness and life satisfaction.

Although the subject of less attention than schools and early childhood services as a setting for promoting healthy eating, workplace wellness initiatives incorporating healthy eating messages or changes to the workplace food environment are increasing in popularity around the world. Most available research on the effectiveness of workplace wellness initiatives has come from the US and Europe, with some evidence of modest improvements in employees' nutrition knowledge and self-reported food intake. There is also some evidence that workplace interventions can reduce absenteeism, and improve productivity and profitability, although the evidence is limited.

Women and younger age groups appear easier to reach than other groups through workplace wellness initiatives. Advances may be made in positively influencing diets in harder-to-reach groups by fostering improvements to work–life balance – for example, by allowing more time and flexibility for healthy food shopping and preparation, thereby increasing self-efficacy and control. Workplace initiatives in this direction include giving employees greater control over their work hours, adjusting shift-work schedules and reducing work-related sources of stress. However, no published interventions measuring the impact of these strategies on diets are available.

## Physical environment

The physical environment influences diet at both the community and household levels. At the community level, the number and mix of food retail and food service outlets; their walkability or proximity to public transport options; and the range, cost and quality of foods available all play a critical role in shaping eating behaviours and their social distribution.

An ‘obesogenic’ local food environment is one that combines an overabundance of unhealthy food outlets and products and a relative lack of affordable healthy food options. Internationally, obesogenic food environments tend to be concentrated in lower-income, less advantaged areas and to be associated with increased risk of unhealthy diets and obesity. In Australia, healthy foods also tend to be less available, more expensive and of lower quality in remote areas than in more densely populated regions.

Inside the home, a wide range of environmental influences can affect food shopping, meal preparation and eating habits. These include space and equipment for food preparation, cooking and storage, home and kitchen layout more broadly, thermal comfort and ability to afford heating/cooling and fuel bills, and the sense of privacy, security and personal safety.

Local food environments are widely recognised as important entry points for actions to promote healthy eating. If not planned properly, however, interventions can exacerbate existing inequities in food access and healthy eating. Farmers’ markets and community gardens, for example, will contribute to efforts to reduce the social gradient in healthy eating only if disadvantaged groups find them accessible and affordable. If planned properly, the benefits of community-garden projects can extend beyond diets to promote mental and emotional health, social interaction and community cohesion.

In addition to improving the availability of healthy food options in disadvantaged neighbourhoods, addressing the social gradient in healthy eating behaviours requires improvements in housing quality, space and location (including adequate food storage and preparation space), transport options, the quality of the built environment, and access to quality social support and health services for disadvantaged groups.

## Social participation

Markers of low social participation include being forced through lack of income and material resources to forfeit the social pleasures of eating out, of eating in other people’s homes or of having guests for a meal. Functional constraints arising from advanced age, disability and/or lack of access to a car or reliable transport can also limit social engagement, as well as contribute directly to food insecurity by diminishing ability to access food retail outlets and to carry groceries. Australian households in disadvantaged areas, and in which the main food shopper has a low level of educational attainment or a low income, or is unemployed, are also likely to experience difficulties in accessing a car.

Strong social and welfare networks can mediate these effects by facilitating social engagement, enabling access to transport and food outlets, and supporting shared food preparation and meals.

Whole-of-community demonstration projects combining nutrition education, community kitchens and gardens, skill building for budgeting, food shopping and preparation, and awareness-raising campaigns across Victoria, Australia and internationally have reported positive impacts on eating behaviours – such as reducing unhealthy weight gain, particularly in children and adolescents. There is also evidence that they can be effective in creating positive change in the social environment and in reducing health inequities.

While there has been a dominant focus in these interventions on school environments, many have actively sought to promote civic engagement, community participation and relationship building as a means of promoting healthy lifestyle behaviours. All available evaluations of community-based obesity-prevention projects conducted in Australia have reported positive impacts on reducing unhealthy weight gain in children and adolescents, and on increasing community cohesion and social capacity. Unfortunately, the differential impacts of these interventions have rarely been examined, although there is some limited evidence that they may be effective in reducing the socioeconomic gradient in child overweight.

Due to their whole-of-community approach, these interventions are inherently complex to implement and evaluate, and require considerable investment from both government and non-government sectors. Sufficient planning time, clear governance structures, partnership development and long-term community commitment appear critical to their success.

## Health care services

Health care services, including community and Aboriginal health centres, Medicare Locals and community pharmacies, offer additional potential settings for promoting equity in healthy eating. These settings can directly influence diets through the mix of foods and beverages they have available, as well as through the provision of nutrition-related education and support. More indirectly, their accessibility and inclusiveness can affect willingness and time to seek care or support among different social groups.

Provision of nutrition education and counselling through primary health care settings has shown modest promise in promoting improved knowledge, awareness and behaviours. However, interventions do not always have a sustained effect on behaviours in the long term. The chances of success are likely to be maximised by targeting high-risk groups, particularly those – such as pregnant women – who interact regularly with health care providers, by addressing access issues and by ensuring the availability of multicultural health workers.

## Individual health-related factors

A range of individual health-related factors influence food choices and diet quality, including personal taste, nutritional-related knowledge, cooking skills and confidence, access to credible information, peer influence and social support for healthy eating (particularly from a partner or other family members). Less advantaged social groups in Australia report having lower understanding of healthy eating messages, lower confidence in cooking skills and poorer social support for healthy eating than their more advantaged peers.

The overwhelming majority of evidence on the effectiveness of interventions to promote healthy eating is at the individual level. At best, well-designed and -executed actions at this level can achieve modest, short-term improvements in individual health-related knowledge and awareness. However, providing healthy eating information and education, without intervening at the other two levels of the Fair Foundations framework, is unlikely to be sufficient to reduce the social gradient in diet quality and may even exacerbate existing inequities, with uptake and impact consistently shown to be higher among higher socioeconomic and otherwise advantaged groups.

Actions aimed at changing individual knowledge, attitudes and behaviours relating to healthy eating can broadly be classified into three categories: public awareness campaigns, nutrition education and skill-building programs.

### Public awareness campaigns

Public awareness campaigns use organised communication strategies to create awareness and change behaviour in the general population through a range of channels, including mass media (television, radio, newspapers and magazines), as well as social media, billboards and other outdoor advertising, local-community settings and events, and food-based dietary guidelines. Well-designed and -executed, and sustained, mass media public-information campaigns can result in modest population average improvements in knowledge, awareness and attitudes. However, they have been much less successful in translating into behaviour change and have been consistently shown to be more successful in improving knowledge, attitudes and behaviours among women, and more educated and higher socioeconomic status groups.

### Nutrition education

Nutrition-education programs tend to be resource intensive, making them challenging to implement in low-resource settings in the absence of external support, and the evidence of their effectiveness is mixed. Combining nutrition education with other strategies appears to improve effectiveness. For example, a combination of specialised nutrition-education curricula, environmental and policy changes, and parental/family involvement appears to be effective in improving healthy eating in school children.

Given that intervention studies involving nutrition education have consistently reported an overrepresentation of women, people from higher socioeconomic positions and otherwise advantaged groups, it is essential that education campaigns target individuals and social groups at greatest risk of unhealthy diets. Internet-based interventions have been identified as a potentially cost-effective strategy for reaching isolated or hard-to-reach groups, although the evidence base for this approach is still limited. In addition to targeting high-risk groups, the provision of more resource-intensive interventions – such as one-on-one counselling – and ensuring that support is provided over an extended period of time, are likely to increase effectiveness.

### Skill building

Interventions aimed at improving food-shopping and -preparation skills (such as food-literacy programs, cooking and food-tasting programs, supermarket tours and budgeting advice), as well as food-production skills (such as home-, school- and community-garden programs), have been the subject of less attention in the intervention literature. However, the combination of school- and after-school-garden programs with nutrition-education curricula have shown promise for improving knowledge, skills and behaviours, including children's willingness to try new, healthy foods.

There is weaker evidence bearing upon the potential of food-shopping and -preparation skill-building programs to lead to long-term behaviour change, although interventions to date have shown modest short-term improvements in eating behaviours. Key equity considerations include ensuring community ownership from the outset, offering classes in familiar community locations (such as cafes, community kitchens or childcare centres), providing flexibility with class times and locations, staffing childcare centres with experienced childcare workers, and considering the provision of incentives (such as vouchers for the local grocery store or for cooking equipment, or certificates or recognised credentials on completion of the program) to promote recruitment and retention of disadvantaged groups.

# Priority actions

## Priorities for all actions seeking to address health inequities:

- Coordinate a blend of measures across all three layers of the Fair Foundations framework, with particular emphasis on, and investment in, the lower two layers to rebalance the current emphasis on individual-level health factors.
- Seek to address both inequities in health outcomes and the wider social determinants of these inequities.
- Incorporate explicit equity objectives.
- Apply principles of proportionate universalism: interventions should be universal, but the level of support should be proportionate to need.
- Ensure that targeted supports do not stigmatise particular groups.
- Promote active and meaningful engagement of a wide range of stakeholders, and increase the diversity of representation at all stages of development and implementation.
- Conduct a thorough assessment of the needs, assets, preferences and priorities of target communities.
- Allocate adequate, dedicated capacity and resources to ensure sufficient intensity and sustainability.
- Monitor and evaluate differential impacts across a range of social indicators to ensure that they achieve their objectives without doing any harm, as well as to strengthen the evidence base for future interventions.
- Invest in equity-focused training and capacity building in both health and non-health sectors, from front-line staff to policy and program decision-makers.
- Make strategies flexible and adaptable at the local level.

## Priorities for action within each layer of the Fair Foundations framework:

### Socioeconomic, political and cultural context

- Regulate to restrict marketing of foods high in fat, salt and sugar to children across all dominant forms of media.
- Preferentially target nutrition-labelling policies at population groups at highest risk of unhealthy eating and address barriers to their use. Consider complementary interventions to enhance effectiveness.
- Implement fiscal-policy packages combining taxes on unhealthy foods with subsidies on healthy foods, ideally as part of a multistrategy approach.
- Regulate to eliminate trans fats and reduce salt in processed foods, and incentivise manufacturers to make reformulated products the same price or cheaper than less healthy substitutes.
- Improve affordability of a healthy diet through social-protection and welfare policy and redistributive taxation, by raising the minimum wage and by labor policies, such as providing flexibility in work hours.
- Align agriculture and trade policy with public health and nutrition goals and commitments, including international nutrition and obesity/non-communicable disease prevention goals, and the Australian Dietary Guidelines.

### Daily living conditions

- Promote healthy weight and provide comprehensive support to mothers before, during and after pregnancy, including family-friendly social-protection policies that guarantee adequate income and maternity benefits, and allow parents to balance their time spent at home and work.
- Implement multicomponent whole-of-school interventions that account for social and cultural variations in food preferences.
- Develop strategies to ensure that local food environments, including community gardens and farmers' markets, are accessible to disadvantaged groups. Explore the potential of alternative initiatives, such as food hubs, food-delivery schemes and food co-ops.
- Improve urban design and public transport infrastructure to facilitate access to healthy food, such as making space and resources available for home and community food production, ensuring that retail planning supports a diverse and balanced range of food outlets in disadvantaged neighbourhoods, and linking food stores to accessible public and active transport options.

# Priority evidence gaps

- Provide incentives for retail stores to sell fresh, healthy foods, and to preferentially promote these over unhealthy foods (e.g. having fresh fruit and vegetables – instead of confectionery – on special at check-outs).
- Target disadvantaged groups, including those with low literacy skills, with clear, easy-to-use and -understand nutrition labels on packaged foods and menu labelling in food service outlets, and implement complementary interventions to enhance their effectiveness among disadvantaged groups.
- Improve public-housing location and quality, including linking all new housing developments to integrated transport plans that prioritise active transport and access to a range of fresh-food retailers, considering space and resources for home or community food production, and ensuring adequate food storage and preparation space within homes.
- Develop nutrition education, advice and counselling in primary health care settings for individuals at highest risk of unhealthy diets. Multicultural health workers can improve effectiveness.

## Individual health-related factors

- Tailor public education campaigns to specific populations and to the sociocultural contexts within which food choices are made. Shape messages to address the process by which food-purchase decisions are made, particularly in low-income groups, and raise awareness of how affordable foods can be used for both nutrition and satiation.
- Focus education campaigns on specific target foods and nutrients, and deliver them through multiple channels.
- Tailor education and skill-building programs to the needs of specific disadvantaged groups, hold them in familiar community locations, provide flexibility in times and childcare support, and include explicit strategies to recruit and retain disadvantaged groups and individuals.

Distributional effects of healthy eating policies, programs and projects across a wide range of indicators of social position (beyond current focus on income and socioeconomic status).

- High-quality, equity-focused evaluations of healthy eating interventions with long-term follow-up.
- Understanding of why and how certain actions have worked to promote equity in healthy eating in different sociopolitical and organisational contexts, including through retrospective evaluations.
- Prospective action-oriented applied research on healthy eating interventions at all levels, with a focus on collaborative knowledge production and intersectoral participation.

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