

About Fair Foundations and promoting health equity

A resource to support Fair Foundations: The VicHealth framework for health equity





Acknowledgements:

This resource was written by Dr Libby Hattersley, Leanne Carlon and Kerryn O'Rourke.

© VicHealth 2015
September 2015 P-EQ-265

Suggested citation:

VicHealth 2015, *About Fair Foundations and promoting health equity*.
Victorian Health Promotion Foundation.

Contents

4	Introduction
5	The social determinants of health inequities
5	Health equity
5	Social position and the social gradient in health
6	The social determinants of health and health inequities
6	Psychosocial approach
6	Social production of disease/political economy of health approaches
6	Eco-social frameworks
7	The Fair Foundations framework
7	Socioeconomic, political and cultural context
8	Daily living conditions
8	Individual health-related factors
8	Differences in health and wellbeing outcomes
9	Using the framework
9	Health equity practice
9	Universal approaches
9	Targeted approaches
10	Combining universal and targeted approaches to address gaps or gradient
10	Life-course approaches
10	Settings approaches
11	Whole-of-systems approach
11	Health equity planning tools
11	Monitoring and evaluation
13	Conclusion and further resources
14	Glossary
16	References

Introduction

VicHealth is committed to promoting fairness and opportunity for better health (VicHealth 2013a). In support of this commitment, VicHealth has developed Fair Foundations: The VicHealth framework for health equity (VicHealth 2013b), as a conceptual and planning tool to guide action on the social determinants of health inequities. Fair Foundations draws on a conceptual framework developed by the World Health Organization (WHO) Commission on the Social Determinants of Health (Solar and Irwin 2010).

To supplement Fair Foundations, this supporting resource outlines the key concepts and theories that underpin the framework and acts as a reference document to increase understanding of the social determinants of health inequities and how to address them in practice.

The social determinants of health inequities

In any society, differences in health outcomes will exist due to natural biological variation (sex, age and genetic make-up, for example). 'Equity in health is not about eliminating all health differences so that everyone has the same level of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair' (Whitehead 1990, 220).

Health equity

Equity is a concept based on the human-rights principles of social justice and fairness (Kawachi, Subramanian et al. 2002, Braveman and Gruskin 2003). It is an approach that addresses the unfair and avoidable differences among social groups with an aim of achieving more equal outcomes.

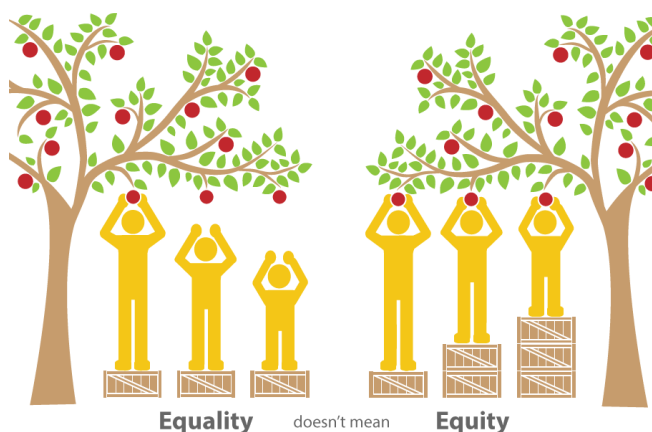
Health equity refers to the absence of systematic or avoidable disparities in health between groups of people, whether these groups are defined socially, economically, geographically or demographically (Whitehead 1992, Whitehead and Dahlgren 2006, WHO 2014b).

Health outcomes do differ between groups; however, **health inequities** are the differences in health outcomes and their risk factors between social groups that are socially produced, systematic in their distribution, avoidable, unfair and unjust (Whitehead 1992).

'Equity' is sometimes used interchangeably with the related term 'equality', although the two are not the same thing.

Equality is considered to exist when all individuals and groups of people are given equal treatment, regardless of need or outcome, whereas an equitable approach focuses on more equal outcomes, recognising that disadvantaged groups may need more support or resources in order to achieve the same health outcomes as more advantaged groups (Marmot 2010).

Figure 1: A visual depiction of the difference between equality and equity



©2015, Saskatoon Health Region

Social position and the social gradient in health

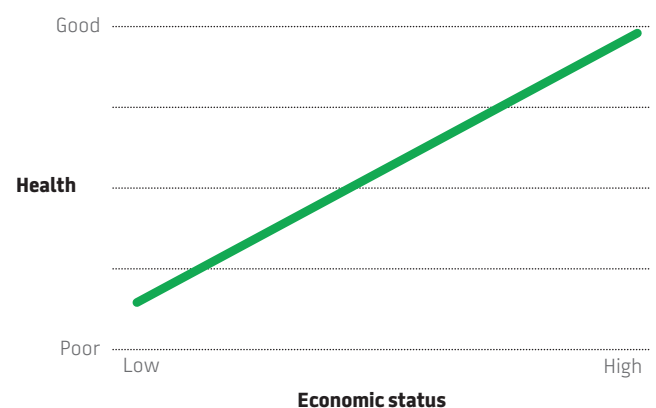
Differences in health outcomes between social groups are often defined according to socioeconomic status, or socioeconomic position, which is a composite measure of educational attainment, living conditions, income and occupational characteristics (such as whether a job involves manual or non-manual labour), as well as the level of prestige, power, control or social standing associated with these (Adler, Boyce et al. 1994, Solar and Irwin 2010).

Socioeconomic status is a major predictor of health outcomes (CSDH 2008). However, differences in health outcomes are also influenced by a number of other factors, including race/ethnicity, disability, aboriginality, and characteristics of the area and neighbourhood in which people live (including rurality and access to key services). The Fair Foundations framework uses the broader concept of **social position** to encompass all of these key markers of social advantage or **disadvantage** (Solar and Irwin 2010).

The process by which individuals become assigned to different positions in the social hierarchy is known as social positioning, or **social stratification**.

The graded relationship between social position and health, where health outcomes progressively improve with increasing social position, is known as the **social gradient in health** (Marmot 2004). In Australia, as in most other countries, clear social gradients exist for a range of preventable health conditions and their behavioural risk factors, including overweight and obesity, type 2 diabetes, cardiovascular diseases, and tobacco use, risky alcohol consumption, poor nutrition and inadequate physical activity (Friel 2009).

Figure 2: A visual representation of the social gradient in health



Adapted from Kelly (2010)

The social determinants of health and health inequities

The conditions in which people are born, grow, live, work, play and age assume a major role in shaping health outcomes (CSDH 2008). Collectively, these are known as the **social determinants of health**.

The underlying social structures and processes that systematically assign people to different social positions and distribute the social determinants of health unequally in society are the **social determinants of health inequities** (Solar and Irwin 2010).

This process of social stratification, in turn, results in the unequal distribution of power, money and resources. Different groups – depending on their ability to exercise power and to access money and resources – have **differential exposure** and/or **vulnerability** to a range of daily living conditions, or the circumstances in which they are born, grow, live, work and age. Examples of differential exposure include the degrees of exposure that different social groups have to overcrowded housing, to sedentary work, or to fruit and vegetable retailers. An example of differential vulnerability is some groups' higher vulnerability to alcohol-related harm, even when their exposure (consumption) levels are similar to other groups' (Makela 1999). The quality of people's daily living conditions affects their material circumstances, psychosocial control and social connection, and is therefore protective of or damaging to health (Solar and Irwin 2010).

The distinction between the social determinants of health and the social determinants of health inequities is important. Actions to address the social determinants of health that do not tackle their distribution, or the structures and processes driving the unequal distribution of power, money and resources are unlikely to address persistent health inequities. Addressing the social determinants of health inequities requires an inherently political approach that engages the responsibility of the state, addresses the inequitable distribution of power, money and resources in society, and enables and promotes social participation and empowerment (Solar and Irwin 2010).

While much is now known about the social determinants of health inequities, less is known about their precise causal pathways. Three broadly complementary theoretical approaches have been used to explain these pathways and the mechanisms by which they operate. These theoretical approaches have informed the development of the conceptual framework developed by the WHO Commission on the Social Determinants of Health (Solar and Irwin 2010), and Fair Foundations. All emphasise the role of social position in generating health inequities.

Psychosocial approach

According to the psychosocial approach, an individual's perceptions and experiences of their place in the social hierarchy shape their vulnerability to illness (Raphael 2006). For example, comparing status, possessions and other life circumstances with those of others can lead to feelings of envy, shame and worthlessness, which in turn lead to unhealthy physical and psychological responses. Attempts to alleviate such feelings may then develop – for example, overspending or working additional shifts, which may induce chronic stress, and/or adopting behaviours such as overeating, smoking and drinking at levels that are detrimental to health. Social inequity also weakens social bonds and cohesion, and this can interact with an individual's sense of control over life's circumstances (Cassel 1976, Lynch, Smith et al. 2001, Wilkinson and Pickett 2006).

Social production of disease/political economy of health approaches

Social production of disease/political economy of health approaches argue that the ultimate determinants of health lie in the political and economic decisions made by governments. These decisions cause and exacerbate income and health inequities that exist on account of individuals' lack of resources, and fuel further inequity in case of underinvestment in public infrastructure to support living conditions and the structures within which they prevail (Doyal 1979, Bamba, Fox et al. 2005, Raphael and Bryant 2006, Solar and Irwin 2010). According to this perspective, governments that are more committed to redistributive social and economic policies, particularly taxation models, are generally more successful in improving the health of populations (Navarro and Shi 2001, Wilkinson and Pickett 2010).

Eco-social frameworks

Several eco-social frameworks have been developed in attempts to advance a multilevel understanding of the determinants of health, incorporating social, biological and ecological perspectives (McMichael 1996, Susser and Susser 1996, Krieger 2001, Krieger 2002, Susser 2004, Krieger 2005). These approaches suggest that you cannot understand the determinants of health inequities without understanding the history of both individual and societal ways of living (Solar and Irwin 2010).

The Fair Foundations framework

Fair Foundations depicts the social determinants of health inequities as three layers of influence:

1. Socioeconomic, political and cultural context;
2. Daily living conditions; and
3. Individual health-related factors.

These three layers of influence and the pathways between them are depicted as a network of tree roots. A main trunk root runs vertically up towards the surface, representing the major and broad lineal pathway running through all of the layers. Minor roots flowing out from the main trunk, occasionally crossing between layers, reflect the multiple, complex and reciprocal nature of the relationships between the layers. Social position runs through the centre of the framework, effecting the distribution, or differing nature, of influence each layer has on people of different social positions.

The socioeconomic, political and cultural context is positioned at the base of the framework. This highlights the deep and powerful role these structural determinants – the ‘causes of the causes’ – have on health. Institutions, structures and processes within the socioeconomic, political and cultural context give rise to the process of social stratification, where the population is ordered according to income, occupation, education, gender, sexuality, race/ethnicity, aboriginality, place-based or locational disadvantage, and other factors. They also shape people’s daily living conditions across the life course, including levels of social connection and psychosocial control. These material and social circumstances can be either protective of or damaging to health, with individuals experiencing differential exposure and/or vulnerability to health-damaging conditions based on their social position. For example, even when alcohol consumption is similar across socioeconomic groups, alcohol-related harms follow a social gradient. People of lower social position appear to be more vulnerable to alcohol-related harms (Makela 1999).

Individual health-related knowledge, attitudes and behaviours result from, and are responses to, the first two levels of the framework. These individual-level factors represent the final layer of influence on health; however, the unequal distribution of health and wellbeing outcomes, and their economic and social consequences, reflect the process of social stratification that begins at the structural level.

Poor health and its consequences (such as a reduced ability to work and earn an income) can also feed back into the causal pathway in a reciprocal nature, worsening the social position. The consequences can also impact at the societal level (Solar and Irwin 2010). A notable example might be how an increasing prevalence of obesity creates additional societal and economic burdens, meaning more resources are required for individual treatment and care, which results in fewer resources being allocated to prevention.

Socioeconomic, political and cultural context

The socioeconomic, political and cultural drivers include governance, policy, and dominant cultural and societal norms and values.

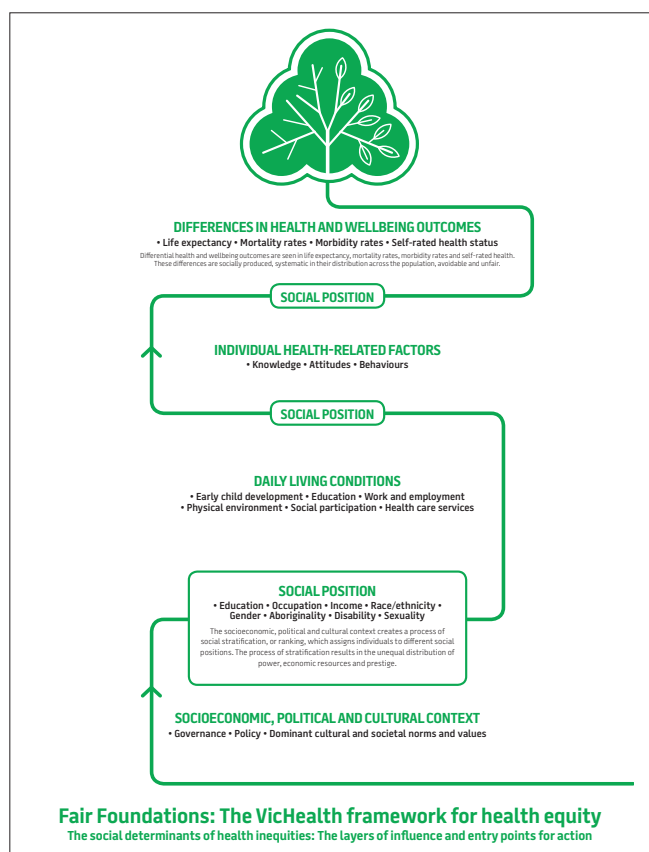
Governance refers to the system of values, policies and institutions by which society manages economic, political and social affairs through interaction within and among the state, civil society and the private sector. It includes how and by whom societal needs are defined, civil participation, accountability and transparency in public administration. It also includes the laws, rules and practices that set limits and provide incentives for individuals and organisations.

Policy refers to macroeconomic and social policies, including fiscal policy, trade, labour-market structures and social welfare, land and housing, education, health and medical care, transport and sanitation.

Dominant cultural and societal norms and values constitute an important part of the context in which policies are developed and implemented. Some examples relevant to social stratification include societal norms and values around gender, race or ethnicity, sexuality and disability that devalue women, people from non-Anglo-Australian backgrounds, lesbian, gay, bisexual, transgender and intersex people, and people who have a disability.

Advocacy is often an important means with which to address the base layer of the framework, where a more concerted and multifaceted approach needs to be taken to change the socioeconomic, political and cultural determinants of health inequities. Building a broader commitment to addressing identified needs, seeking support for new or different services, pursuing resources to meet the community’s need or speaking out on issues can all be important advocacy strategies to address inequity (Vilshanskaya and Stride 2003).

Figure 3: Fair Foundations: The VicHealth framework for health equity



www.vichealth.vic.gov.au/fairfoundations

Daily living conditions

Daily living conditions represent the everyday circumstances in which people live. The quality of these conditions affects people’s material circumstances, psychosocial control and social connection, and can be protective of or damaging to health. Social stratification means that different social groups have differential exposure and/or vulnerability to a range of daily living conditions. Daily living conditions are both determinants of health – such as educational attainment – and settings, such as schools, in which action can be undertaken.

Early childhood development refers to physical, social, emotional, language and cognitive development between the prenatal period and eight years of age. There is substantial evidence that early childhood is the most important developmental phase in the lifespan and a critical age that provides one of the greatest potential targets for reducing inequities in health (CSDH 2008).

Education refers to the development of knowledge and skills for problem solving, and a sense of control and mastery over life circumstances. Education increases work opportunities, job security, satisfaction and income.

Work and employment refers to the nature of employment and working conditions, including job security, flexibility, control, physical working conditions and social connection.

Physical environment refers to built and natural environments, including housing, transport systems, air quality, place of residence, neighbourhood design and green space.

Social participation refers to supportive relationships, involvement in community activities and civic engagement. Social participation is one of the key mechanisms for redistributing power by broadening opportunities for participation in decision-making and implementation processes, which is critical to individual agency and control.

Health care services refers to preventive and treatment services. Accessibility of health care services is central to their performance in meeting health care needs. ‘Access’ can be defined as the opportunity to identify health care needs, to seek health care, to reach, obtain or use health care services, and to have the need for services fulfilled (Levesque, Harris et al. 2013). An individual’s access to affordable, appropriate health care is strongly influenced by their health literacy – their capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions (Institute of Medicine 2004). Health literacy is an outcome of interactions between the individual and their socioeconomic, political and cultural environment, with the health and education systems playing a particularly important role.

Individual health-related factors

Individuals’ health-related knowledge, attitudes and behaviours result from, and are responses to, the influences of the preceding layers of the framework.

These wider social determinants produce differences in individual knowledge, attitudes and behaviours. Within Australia and internationally, major inequities exist in health-damaging behaviours, including tobacco use, risky alcohol consumption, unhealthy eating patterns and inadequate physical activity. These inequities exist across a range of measures of social position, including lower socioeconomic status (income, education and occupation), locational or place-based disadvantage (Friel 2009, Solar and Irwin 2010).

While there is generally common agreement in **health promotion** for the need to focus on the determinants of health and health inequities, an emerging focus on individual lifestyle change seems apparent (WHO 2009). Phrased as a **lifestyle drift**, this is the tendency for broad recognition, and often policy development, around the need to take action on the wider social determinants that drift downstream to focus largely on individual lifestyle factors (Hunter, Popay et al. 2009).

Differences in health and wellbeing outcomes

Finally, different social groups experience differential consequences of ill health, including differences in life expectancy, mortality and morbidity rates, and self-rated health.

Using the framework

Each layer of the framework represents a possible entry point for action. Action can be taken at any or all layers and there is no correct place to start. However, a comprehensive approach to tackling health inequities must include actions at the base of the framework that address the social structures and processes that systematically distribute the determinants of health unequally in society.

There is recognition that working at the base layers is not always possible. This inability may arise from the type of organisation undertaking the work, the parameters set by funding programs or other constraints that expect work to be undertaken at the individual health layer of the framework. Additionally, some organisations are better placed to influence structural determinants and/or daily living conditions than others.

It is important to recognise both organisational and project limitations to working at the base layers. While being realistic about what can practically be achieved, it is also necessary to be mindful of the structures and conditions impacting on the current behaviours, attitudes and knowledge of the individuals among whom change is being sought. If the work is unable to focus on the determinants of inequity, and is undertaken only at the individual level, those who have the least structural barriers will be more likely to benefit from the work; therefore, the work will increase the steepness of the social gradient. Evidence across a range of risk factors shows that work at the individual behaviour change layer alone will also be less likely to sustain ongoing changes. For example, a recent review of programs focusing on individual behaviour change – providing increased outdoor free-play time, or health information for children and parents – resulted in no benefits for Body Mass Index, diet or television viewing time (Hesketh and Campbell 2010).

Fair Foundations can be used as an advocacy tool to support work across the base layers of the framework, in addition to individual behaviour change. The following practice principles can also aid the development of health promotion action that is more likely to have equitable outcomes.

Health equity practice

Fair Foundations advocates the need for a mix of strategies that tackle the structures and processes within the socioeconomic, political and cultural context that shape the social hierarchy and people's daily living conditions, and individual-level determinants. This requires action, cooperation and joint accountability for health equity across multiple sectors and levels of government (WHO 2014b). Comprehensive approaches that involve a combination of actions and focus on a range of determinants have been consistently shown to be most effective in reducing inequities.

An equitable approach means addressing need and aiming for more equal outcomes. Actions that benefit all social groups equally will not reduce the gap between the most and least disadvantaged or flatten the social gradient in health. At the same time, approaches targeting only high-risk groups are unlikely to be effective on their own because they do not address the social gradient across the whole population, and have the potential to stigmatise the groups they are trying to reach (WHO 2014b).

Universal approaches

Universalism is an important contributor to the production of healthy outcomes. Good evidence for this is that countries with universal health care, welfare and education tend to enjoy a higher general health status and are able to reduce health inequities (Baum 2008). **Universal approaches** are open to the whole population, or to a defined population (such as all women or all people from a particular location), without recognising differences in social position (Perlman 2012). When universal approaches do not consider and incorporate the needs of people experiencing disadvantage, they are likely to exacerbate inequities by disproportionately benefiting people with the power, money and resources that enable engagement and/or adoption of the desired change (Marmot 2010). However, universal approaches can at times be more effective than targeted approaches in reaching people – 'hidden' in average data – who are living in disadvantaged circumstances or who come from disadvantaged backgrounds (Newman, Javanparast et al. 2014).

High-quality universal approaches that incorporate the needs of people who experience disadvantage often meet the needs of a larger number of people. For example, universal design principles applied when designing a new building incorporate the needs of all potential users. It is a one-size-fits-all approach, rather than a one-size-fits-most (or -some).

Targeted approaches

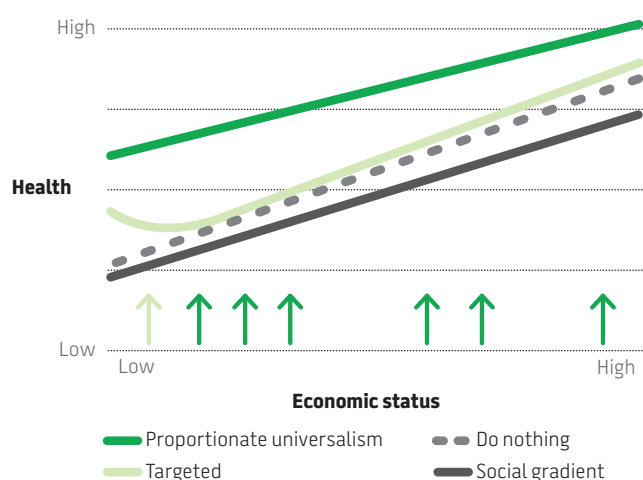
Targeted approaches are important as they can reduce gaps in health status between groups (Vilshanskaya and Stride 2003). Targeted approaches can, however, lead to reluctance, shame and stigma for people being provided with the targeted, free or subsidised program or resources (Davies and Sheriff 2012). Additionally, targeted work, particularly where resources are limited, can encourage population groups to pit against each other, creating divisions within and among communities (Powell 2012).

Combining universal and targeted approaches to address gaps or gradient

The most effective approaches act across the whole social gradient, but achieve faster and greater improvements in health for those further down the social gradient. This can be achieved by tailoring the focus and intensity of support proportionate to need. This approach of combining universal programs with targeted measures that provide extra support to those with the greatest disadvantage and need is referred to as **proportionate universalism** (also called ‘targeted universalism’ or ‘progressive universalism’) (Marmot 2010). Extra support may include increased intensity or duration for different groups. Taking action to improve the overall health of the population, thereby reducing the steepness of the social gradient, is referred to as **levelling up** (Whitehead and Dahlgren, 2006).

An additional method of combining universal and targeted approaches is one that aims to address the gap between one population group and the rest of the population. To reduce a health gap is to improve the health of a particular population group at a rate greater than that of the whole population. Typically, this is a focus on those with the poorest health (Kelly, Morgan et al. 2007). An example of work that aims to address a health gap in Australia is ‘Close the Gap’. This work specifically aims to reduce the gap between Indigenous and non-Indigenous Australians’ health outcomes.

Figure 4: A visual representation of the effect of different approaches to reduce health inequities



Adapted from Health Inequalities Commissioning Framework – NHS Kensington and Chelsea (2011)

Life-course approaches

The social determinants of health inequities work interactively with, and are mediated by, biological factors that shape individual health outcomes and their risk factors over the life course. The effects of social disadvantage accumulate and interact throughout a person’s life, from birth through to old age (Kawachi, Subramanian et al. 2002). Therefore, comprehensive approaches that include a mix of strategies targeting different stages of the life course, with particular emphasis on the early childhood years, are important. Fair Foundations identifies the need to invest in strategies to address disadvantage in mothers, infants and young children as being critical in giving children a better start in life, and shaping health across the entire life course, and possibly across generations. Further details of what has been and can be undertaken to reduce inequities in early childhood are available in the resource, ‘Promoting equity in early childhood development for health equity through the life course’ (VicHealth 2015).

Settings approaches

Making the everyday settings of people’s lives – where they live, learn, play and work – more supportive of healthy outcomes has long been recognised by health promoters as an optimum way to improve population health (Newman, Javanparast et al. 2014). The WHO’s Ottawa Charter (1986) recognises that health is created and lived by people within these settings and that policies and institutional practices shape the opportunities people have to lead healthy lives. Addressing social determinants within settings is the most significant way to improve health equity (CSDH 2008, Marmot 2010, Marmot, Allen et al. 2012).

Working within settings, as opposed to priority population groups, removes the focus from the person to the setting, reducing any stigma or shame that may otherwise be felt (Newman, Javanparast et al. 2014). An example of settings work is the development of structures and systems that enable more women to feel welcome and included within a sports club. A common approach to settings work that is less effective is the focus on changing individual behaviours within a setting, rather than changing the setting itself (Newman, Javanparast et al. 2014). For example, offering activities for women, without addressing the environmental and attitudinal barriers to women’s participation in sport.

Further details of working in settings to improve health equity are available in the ‘Promoting health equity through addressing social determinants in healthy settings approaches’ resource.

Whole-of-systems approach

A system is made up of a structure, the process it supports and its use. Elements are generally both interdependent and related, all of which need to be considered as a whole (Davies and Sheriff 2012). A systems approach therefore needs to understand the links and relationships between each component. To tackle the gradient in health inequities, a whole-social-systems approach is required (Marmot 2010), particularly when addressing complex strategic and social issues. A whole-of-systems approach looks at the ‘big picture’ of issues across a range of different stakeholders (Davies and Sheriff 2012). For example, to address food insecurity for families experiencing disadvantage and therefore to improve healthy eating among school-aged children, Fair Foundations identifies the need to work within the causal pathways. A whole-of-systems approach helps to do this by ensuring that all stakeholders are focused on the work of identifying ways to address the problem. This might, for example, bring together the local school, families, local retailers, community health services and all levels of government, enabling each to work in partnership with the others. In a scenario such as this – with multiple agencies working to facilitate a single outcome – each layer of the framework is more likely to be addressed.

Health equity planning tools

Fair Foundations, as a conceptual framework, is designed to guide action to improve equity across any public health issue and at any entry point across each of the layers of the framework. Not all approaches to health promotion, and not all initiatives designed to address the social determinants of health, will inherently or automatically address inequities. An explicit equity focus is required.

Various tools are available for use to incorporate equity into policy and project planning. These can be built into existing planning, process and evaluation structures or be used for stand-alone purposes. The use of an equity lens or other equity planning tool will help to identify, prospectively, potential unintended or **differential impacts**, both positive and negative. It is vital when planning for equity that potential unintended impacts, such as increasing inequity in other areas or increasing stigma, are identified in the planning process. For example:

- Banning smoking at playgrounds may have impacts upon levels of physical activity for children of smokers, as smokers may just stop taking children to the park.
- Providing free services only to those who are disadvantaged may create further stigma or shame, resulting in a lack of take up of the service.

Health equity planning tools are used to prompt policy makers and practitioners to answer a range of questions that will help to ensure that the policy or project will improve health equity or, at a minimum, will not exacerbate inequity (NCCDH 2012). Building equity into the planning of health promotion programs does not mean that all programs must focus on equity, but rather that they are taking equity into account (Gardner 2012).

The Canadian National Collaborating Centre for Determinants of Health (NCCDH 2012) identifies three categories of tools that can be used to strengthen approaches to addressing the social determinants of health and to advancing health equity. These are:

- checklists and lenses – an overlay or integration of prompts within existing planning and implementation activities
- impact assessments – a more comprehensive guide with a structured planning approach to equity (particularly the equity-focused health impact assessment)
- support structures – not an actual tool, but rather a system of support (personnel) built into an organisational structure to support the integration of an equity approach.

The degree or type of approach used will be determined by the resources available, organisational commitment and the policy or project context. It is best to integrate equity as early as possible into the planning phase and to ensure that the process is systematic and transparent (NCCDH 2012). The development of checklists, lenses and impact assessments should fit organisational need and might incorporate:

- explicit equity-related goals and objectives (program logic)
- prospective identification of positive and negative, intended and unintended impacts
- identification of specific equity indicators and measures
- identification of, and ways to address, key access barriers
- a flexible approach to the use of the tools that have been adopted (Gardner 2012).

Fair Foundations’ ‘prompts for planning’ identify some of the questions that can be asked when working at each layer of the framework.

Monitoring and evaluation

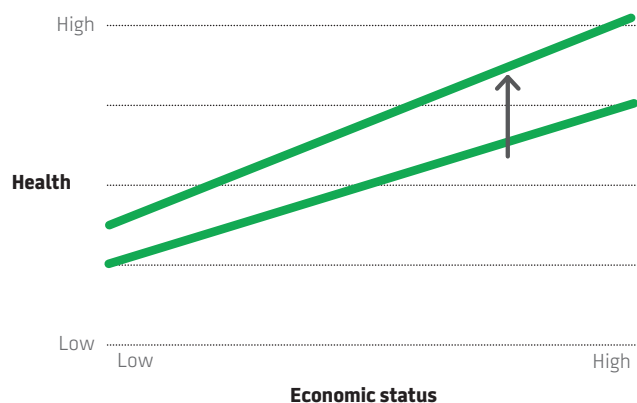
Fair Foundations show the causal pathways of the social determinants of health inequities as multiple, complex and potentially indirect. This means that they often present conceptual and practical challenges for those working to redress them. Monitoring and evaluation of individual programs alone will not explain the ways in which these pathways operate. Rather, systematic, ongoing monitoring of patterns of health inequities and their known causes is essential to the understanding and tracking of the nature and magnitude of inequities in health outcomes and their risk factors over time. There is a need for evaluation and reflection to be undertaken continually and in different forms. Process evaluation can be used during the implementation of strategies to determine how an activity was delivered, whom it worked for and what circumstances led to the activity’s success or failure (Higgins and Green 2008). Similarly, monitoring and evaluation of the impact of strategies implemented is essential to ensure that they achieve their objectives without doing any harm (Bonnefoy, Morgan et al. 2007). It is important to identify any unintended outcomes and the differential impact of interventions.

Health inequities and their risk factors can be measured and described in either **absolute** or **relative** terms. Absolute inequities are about differences between groups, while relative inequities are about ratios, or differences between groups relative to others (Wagstaff, Paci et al. 1991, Mackenbach and Kunst 1997). Relative inequities can be expressed either as differences between disadvantaged groups relative to more advantaged groups, or relative to the population average. Examples of relative measures include rate ratios, relative risk and population attributable risk (Mackenbach and Kunst 1997). Recognition of the importance of relative inequities is at the heart of the concept of the social gradient (Kelly 2010).

The importance of distinguishing between absolute and relative measures of inequities is illustrated in Figure 5. The lower line represents the social gradient in a particular health outcome before a population-level public health action. The upper line represents the social gradient post action, and shows a greater health improvement among those higher up the social gradient. In other words, while the action has successfully improved the absolute health of all social groups, relative health inequities have worsened.

Ultimately, improving health equity requires a reduction in the steepness of the social gradient. An action that achieves overall gains in health in a population in absolute terms will not achieve a positive impact on health inequities unless there is a differential rate of improvement that increases at each step down the social gradient (Kelly, Morgan et al. 2007).

Figure 5: Visual representation of the health gradient, showing widening relative inequities pre- and post-action



Adapted from Kelly (2010)

Any population health actions will ideally result in improvements in both absolute and relative terms, that is, a reduction in the total population disease burden, as well as a greater or faster rate of improvement in more disadvantaged groups relative to those higher up the social gradient (Bonney, Morgan et al. 2007). Therefore, both absolute and relative measures can be meaningful in measuring and describing health inequities, and are ideally used in combination.

Routinely monitoring and evaluating the relative impacts of policies, programs and projects on the health of different social groups is crucial to ensure that they do no harm and are effective in reducing inequities in health (Mackenbach and Kunst 1997). Appropriate indicators for monitoring and evaluating equity impacts will vary between populations and communities according to their particular needs. However, as a guide, differential impacts should be evaluated by:

- Aboriginal/Indigenous status
- race/ethnicity (measured by country of birth, language spoken at home and/or nationality)
- place or residence (measured by postcode or SLA)
- socioeconomic status (measured by education level, individual or household income, employment status, occupational class)
- self-assessed physical and mental health
- disability
- sex
- age
- sexuality.

Conclusion and further resources

Fair Foundations is a conceptual framework that helps to describe the social determinants of health inequities. It identifies the layers of influence where health promotion work can be undertaken to improve population health. By understanding the role of each layer of the framework, including the reciprocal influence upon and of social position, it will support a greater understanding of how to reduce the avoidable and unfair differences in health outcomes. Effort to address the social determinants of health inequities aims to level up the social gradient, leading to a reduction in the burden of disease. Fair Foundations can guide further understanding of the causal pathways of inequities and can, therefore, influence the approaches used when planning, implementing and evaluating health promotion action.

Additional guidance and recommendations for practical action on reducing health inequities can be found in a suite of evidence reviews and their summaries developed by VicHealth. www.vichealth.vic.gov.au/fairfoundations.

Also useful is a series of policy briefs developed by the WHO Regional Office for Europe (WHO 2014b). The series includes detailed recommendations for strategies to address inequities in tobacco-related harm (WHO 2014e), alcohol-related harm (WHO 2014a), overweight and obesity (WHO 2014d), and unintentional injuries (WHO 2014c).

Glossary

Differential exposure – The social complexion of experience such that one person’s experience of things will differ from that of another insofar as the two persons occupy differently advantaged positions within the socioeconomic order. For example, people living in low socioeconomic status (SES) communities typically experience greater exposure to fast-food outlets by virtue of the relatively high density of such outlets in low SES areas.

Differential impact – The socially determined impact of health interventions. Since interventions do not impact all people in the same ways, it is important to evaluate the differential impact of interventions, to measure impact across different groups in the population (Harris-Roxas, Simpson et al. 2004).

Differential vulnerability – The socially based experience of harm, or the proneness to chronic illness that varies according to social position, regardless of the uniformity of risk-factor rates. For example, greater alcohol harms are seen in low SES groups, even though consumption levels are the same across a wide SES spectrum (Makela 1999).

Disadvantage – A term that is often used to describe inequity faced by people of lower social position. It is socially constructed, imposed on people and limits their opportunities in life or health (Vilshanskaya and Stride 2003).

Equality – The state of affairs that prevails when all individuals and/or groups of people are given equal treatment, regardless of need or outcome.

Equity – The state of affairs that prevails when support or resources are distributed according to need, the purpose being to ensure more equal outcomes for all.

Health equity – The notion that everyone 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 (Whitehead 1992).

Health inequalities – A term often used interchangeably with ‘health inequities’. Health inequalities are unavoidable and include biologically determined differences in health status between population groups. Health inequalities can lead to health inequity (WHO Glossary).

Health inequities – A term that designates the differences in health status between population groups that are socially produced, systematic in their unequal distribution across the population, avoidable and unfair (Whitehead 1992).

Health promotion – The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions (WHO Glossary).

Language – In the present context, ‘language’ draws attention to the need for sensitive application of specific terminology. Terms such as ‘low SES’, ‘vulnerable’, ‘disadvantaged’ and ‘priority populations’ are often used to describe people facing inequities (WHO Glossary). It is important not to exacerbate inequity-based stigma, and not to use language in ways that may open rifts within and between communities. Language must be used respectfully and neutrally; it ought to describe rather than to label. For example, it is preferable to refer to ‘people who experience disadvantage’ than to ‘the disadvantaged’.

Levelling up – Taking action to improve the overall health of the population, reducing the steepness of the social gradient (Whitehead and Dahlgren, 2006).

Life-course approaches – Interventions that target people at a particular stage of life. ‘Life-course effects’ refer to the impacts wrought upon current health status by prior living circumstances (Kawachi, Subramanian et al. 2002).

Lifestyle drift – The tendency for interventions, while commencing with a broad recognition of the need to take action on the wider social determinants of health, to drift downstream to focus largely on individual lifestyle factors (Hunter, Popay et al. 2009).

Proportionate universalism – Also called the ‘gradient approach’, this intervention uses a combination of universal and targeted approaches, their scale and intensity increasing in proportion with need or disadvantage (Marmot 2010). Proportionate universalism is a term commonly used in the United Kingdom. This approach is sometimes referred to as ‘targeted universalism’ or ‘progressive universalism’, particularly in the United States.

Settings approaches – Interventions designed to make the everyday settings of people’s lives – where they live, love, play and work – more supportive of healthy outcomes. The WHO’s Ottawa Charter (1986) recognises that health is created and lived by people within these settings and that policy and institutional practices shape the opportunities people have to lead healthy lives.

Social determinants of health – The social conditions in which people are born, grow, live, work, play and age – that influence their health (CSDH 2008). For example, the quality of education will contribute to an individual's health outcomes.

Social determinants of health inequities – The social determinants of health and the social processes that distribute these determinants unequally (Solar and Irwin 2010).

Social gradient in health – The graded relationship between social position and health, whereby health outcomes progressively improve with increasing social position (Marmot 2004).

Social position – A person's location within the socioeconomic order. Key markers of social position in Australia include educational attainment, occupational status, income level, gender, race/ethnicity, Aboriginality (Solar and Irwin 2010), disability (Emerson, Madden et al. 2011) and sexuality (Leonard 2003).

Social stratification – The process by which individuals become assigned to different positions (or are ranked) in the social hierarchy created by the socioeconomic, political and cultural context. Typically, the process results in the unequal distribution of power, economic resources and prestige (Solar and Irwin 2010).

Targeted approaches – Programs that focus on the specific needs of a particular population group and are often means tested (NCCDH 2013).

Universal approaches – Programs that are open to the whole population, or a defined population (such as all women), without recognising differences in social position (Perlman 2012).

Upstream – A health promotion analogy that refers to working in prevention, with a focus on the social determinants of health. The Fair Foundations framework refers to this as being the base layers of the framework – the root causes.

Wicked problems – A range of social issues so named because of their bedeviling complexities, suggesting that they are not able to be resolved through traditional service-driven approaches (Conklin 2006). These include climate change, poverty, disadvantage faced by Indigenous people, child abuse, family violence, obesity, crime and natural resource management.

References

- Adler NE, Boyce T, Chesney MA, Cohen S, Folkman S, Khan RL, and Syme SL (1994). Socioeconomic status and health. The challenge of the gradient. *American Psychologist* 49(1): 15–24.
- Bambra C, Fox D, and Scott-Samuel A (2005). Towards a politics of health. *Health Promotion International* 20(2): 187–193.
- Baum F (2008). *The new public health* (3rd edn). South Melbourne: Oxford University Press.
- Bonnefoy J, Morgan A, Kelly M, Butt J, and Bergman V (2007). Constructing the evidence base on the social determinants of health: A guide. World Health Organization: Geneva. Available from: http://cdrwww.who.int/social_determinants/knowledge_networks/add_documents/mekn_final_guide_112007.pdf.
- Braveman P, and Gruskin S (2003). Defining equity in health. *Journal of Epidemiology and Community Health* 57: 254–258. <http://jech.bmj.com/content/57/4/254.full>.
- Cassel J (1976). The contribution of the social environment to host resistance. *American Journal of Epidemiology* 104(2): 107–123.
- Conklin J (2006). *Dialogue Mapping: Building Shared Understanding of Wicked Problems*. Hoboken, New Jersey: Wiley.
- CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. World Health Organization: Geneva. Available from: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf?ua=1.
- Davies JK, and Sherriff NS (2012). *The Gradient Evaluation Framework (GEF): A European Framework for designing and evaluating policies and actions to level-up the gradient in health inequalities among children, young people and their families*. Brighton: University of Brighton.
- Doyal L (1979). *The political economy of health*. London: Pluto.
- Emerson E, Madden R, Graham H, Llewellyn G, Hatton C, and Robertson J (2011). The health of disabled people and the social determinants of health. *Public Health* 125(3): 145–147.
- Friel S (2009). *Health equity in Australia: A policy framework based on action on the social determinants of obesity, alcohol and tobacco*. The Australian National Preventative Health Taskforce: Canberra. Available from: [http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/0FB203C1C547A82CA257529000231BF/\\$File/compmpaper-hlth-equity-friel.pdf](http://www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/0FB203C1C547A82CA257529000231BF/$File/compmpaper-hlth-equity-friel.pdf).
- Gardner B (2012). Realizing the Potential of Health Equity Impact Assessment. Ministry of Health and Long-Term Care HEIA Conference Lessons Learned Panel, 28 May 2012. Available from: <http://www.slideshare.net/WellesleyInstitute/mohltc-heia-conf-talk-on-lessons-learned>.
- Harris-Roxas B, Simpson S, and Harris E (2004). Equity focused health impact assessment: a literature review. Australasian Collaboration for Health Equity Impact Assessment: Newcastle. Available from: http://www.healthimpactproject.org/resources/document/Harris-Roxas_B_2004_Equity_Focused_HIA.pdf.
- Hart, R (1992). Children’s Participation from Tokenism to Citizenship. UNICEF Innocenti Research Centre: Florence, as cited in www.freechild.org/ladder.htm.
- Hesketh K, and Campbell KJ (2010). Interventions to prevent obesity in 0–5 year olds: an updated systematic review of the literature. *Obesity* 18(Suppl. 1): S27–35.
- Higgins JPT and Green S (Eds) (2008). *Cochrane handbook for systematic reviews of interventions*. Version 5.0.1. Available from: www.cochrane-handbook.org.
- Hunter DJ, Popay J, Tannahill C, Whitehead M, and Elson T (2009). *Learning Lessons from the Past: Shaping a Different Future*. Marmot Review Working Committee 3 Cross-cutting sub-group report. Available from: <https://www.instituteofthealthequity.org/projects/the-marmot-review-working-committee-3-report/working-committee-3-final-report.pdf>.
- IAP2 (2014). *Public Participation Spectrum*. International Association for Public Participation. Available from: <http://www.iap2.org.au/resources/iap2s-public-participation-spectrum>.
- Institute of Medicine (2004). *Health literacy: a prescription to end confusion*. Washington DC: National Academies Press. Available from: http://books.nap.edu/openbook.php?record_id=10883.
- Kawachi I, Subramanian S, and Almeida-Filho N (2002). A glossary for health inequalities. *Journal of Epidemiology and Community Health* 56: 647–652.
- Kelly M (2010). The axes of social differentiation and the evidence base on health equity. *Journal of the Royal Society of Medicine* 103: 266–272.
- Kelly M, Morgan A, Bonnefoy J, Butt J, and Bergman V (2007). *The social determinants of health: Developing an evidence base for political action*. Final Report to World Health Organization Commission on the Social Determinants of Health. World Health Organization: Geneva. Available from: http://cdrwww.who.int/social_determinants/resources/mekn_final_report_102007.pdf.

- Krieger N (2001). Theories for social epidemiology in the 21st century: an ecosocial perspective. *International Journal of Epidemiology* 30(4): 668–677.
- Krieger N (2002). A glossary for social epidemiology. *Epidemiological Bulletin* 23(1): 7–11.
- Krieger N (2005). Embodiment: a conceptual glossary for epidemiology. *Journal of Epidemiology and Community Health* 59(5): 350–355.
- Leonard W (2003). *Health and sexual diversity: A health and wellbeing action plan for gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*. Ministerial Advisory Committee on Gay and Lesbian Health. Victorian Government Department of Human Services: Melbourne. Available from: http://www.glhv.org.au/files/health_action_plan.pdf.
- Levesque J, Harris M, and Russell G (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health* 12: 18. Available from: <http://www.equityhealthj.com/content/12/1/18>.
- Lynch J, Smith G, Hillemeier M, Shaw M, Raghunathan T, and Kaplan G (2001). Income inequality, the psychosocial environment, and health: comparisons of wealthy nations. *Lancet* 358(9277): 194–200.
- Mackenbach J, and Kunst A (1997). Measuring the magnitude of socioeconomic inequalities in health: an overview of available measures illustrated with two examples from Europe. *Social Science & Medicine* 44(6): 757–771.
- Makela P (1999). Alcohol-related mortality as a function of socioeconomic status. *Addiction* 94(6): 867–886.
- Marmot M (2004). Social causes of social inequalities in health. In: *Public Health, Ethics and Equity*. Anand S, Peter F, and Sen A (Eds). Oxford: Oxford University Press.
- Marmot M (2010). *Fair Society, Healthy Lives: The Marmot Review*. London: University College. Available from: <http://www.instituteoftheequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf>.
- Marmot M, Allen J, Bell R, Bloomer E, and Goldblatt P (2012). WHO European review of social determinants of health and the health divide. *The Lancet* 380(9846): 1011–1029.
- McMichael A (1996). Prisoners of the proximate: loosening the constraints on epidemiology in an age of change. *American Journal of Epidemiology* 149(10): 887–897.
- Navarro V, and Shi L (2001). The political context of social inequalities and health. *Social Science & Medicine* 52(3): 481–491.
- NCCDH (2012). *Tools and approaches for assessing and supporting public health action on the social determinants of health and health equity: Comparative tables*. National Collaborating Centre for Determinants of Health and National Collaborating Centre for Public Health Policy. Available from: http://www.ncchpp.ca/docs/Equity_Tools_NCCDH-NCCHPP.pdf.
- NCCDH (2013). *Let's talk universal and targeted approaches to health equity*. National Collaborating Centre for Determinants of Health. Available from: http://nccdh.ca/images/uploads/Approaches_EN_Final.pdf.
- Newman L, Javanparast S, Baum F, and Hutchinson C (2014). *Settings for addressing the social determinants of health inequalities*. Victorian Health Promotion Foundation (VicHealth).
- NHS Kensington and Chelsea (2011). *Health Inequalities Commissioning Framework*. Available from: <http://www.instituteoftheequity.org/projects/health-inequalities-commissioning-framework-/health-inequalities-commissioning-framework.pdf>.
- Perlman M (2012). *Targeted vs universal intervention*. University of Toronto: Ontario Institute for studies in education. Available from: <http://tinyurl.com/aqtk5e3>.
- Powell J (2012). *Structural fairness and targeted universalism: Reflections on Detroit*. Berkeley: University of California. Available from <http://diversity.berkeley.edu/structural-fairness-targeted-universalism-reflections-detroit>.
- Raphael D (2006). Social determinants of health: present status, unanswered questions, and future directions. *International Journal of Health Services* 36(4): 651–677.
- Raphael D, and Bryant T (2006). Maintaining population health in a period of welfare state decline: political economy as the missing dimension in health promotion theory and practice. *Promotion and Education* 13(4): 236–242.
- Solar O, and Irwin A (2010). A conceptual framework for action on the social determinants of health. World Health Organization: Geneva. Available from: http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf.
- Susser E (2004). Eco-Epidemiology: Thinking Outside the Black Box. *Epidemiology* 15(5): 519–520.
- Susser M, and Susser E (1996). Choosing a future for epidemiology: II. From black box to Chinese boxes and eco-epidemiology. *American Journal of Public Health* 86(5): 674–677.
- VicHealth (2013a). *VicHealth Action Agenda for health promotion*. The Victorian Health Promotion Foundation: Melbourne. Available from: www.vichealth.vic.gov.au/actionagenda
- VicHealth (2013b). *Fair Foundations: The VicHealth Framework for Health Equity*. The Victorian Health Promotion Foundation: Melbourne. Available from: www.vichealth.vic.gov.au/fairfoundations
- VicHealth (2015). *Promoting equity in early childhood development for health equity through the life course*. Available from: www.vichealth.vic.gov.au/fairfoundations
- Vilshankaya O, and Stride V (2003). *Four steps towards equity: A tool for health promotion practice*. NSW Health Promotion Directors Network. Available from: <http://www.preventivehealth.net.au/uploads/2/3/5/3/23537344/4stepstowardsequi.pdf>.
- Wagstaff A, Paci P, and van Doorslaer E (1991). On the measurement of inequalities in health. *Social Science & Medicine* 33(5): 545–557.
- Whitehead, M (1990). The concepts and principles of equity and health. The Regional Office for Europe of the World Health Organization: Copenhagen.
- Whitehead M (1992). The concepts and principles of equity and health. *International Journal of Health Services* 22(3): 429–445.

Whitehead M, and Dahlgren D (2006). *Levelling up (Part 1): A discussion paper on concepts and principles for tackling social inequities in health*. The Regional Office for Europe of the World Health Organization: Copenhagen. Available from: http://www.who.int/social_determinants/resources/leveling_up_part1.pdf.

WHO (2009). *Milestones in health promotion: Statements from global conferences*. World Health Organization: Geneva. Available from: http://www.who.int/healthpromotion/Milestones_Health_Promotion_05022010.pdf?ua=1.

WHO (2014a). *Alcohol and inequities. Guidance for addressing inequities in alcohol-related harm*. The Regional Office for Europe of the World Health Organization: Copenhagen. Available from: <http://www.euro.who.int/en/data-and-evidence/equity-in-health-project/policy-briefs/alcohol-and-inequities.-guidance-for-addressing-inequities-in-alcohol-related-harm>.

WHO (2014b). *The equity action spectrum: taking a comprehensive approach*. The Regional Office for Europe of the World Health Organization: Copenhagen. Available from: <http://www.euro.who.int/en/publications/abstracts/equity-action-spectrum-taking-a-comprehensive-approach-the.-guidance-for-addressing-inequities-in-health>.

WHO (2014c). *Injuries and inequities. Guidance for addressing inequities in unintentional injuries*. The Regional Office for Europe of the World Health Organization: Copenhagen. Available from: <http://www.euro.who.int/en/data-and-evidence/equity-in-health-project/policy-briefs/injuries-and-inequities.-guidance-for-addressing-inequities-in-unintentional-injuries>.

WHO (2014d). *Obesity and inequities. Guidance for addressing inequities in overweight and obesity*. The Regional Office for Europe of the World Health Organization: Copenhagen. Available from: <http://www.euro.who.int/en/data-and-evidence/equity-in-health-project/policy-briefs/obesity-and-inequities.-guidance-for-addressing-inequities-in-overweight-and-obesity>.

WHO (2014e). *Tobacco and inequities. Guidance for addressing inequities in tobacco-related harm*. The Regional Office for Europe of the World Health Organization: Copenhagen. Available from: <http://www.euro.who.int/en/data-and-evidence/equity-in-health-project/policy-briefs/tobacco-and-inequities.-guidance-for-addressing-inequities-in-tobacco-related-harm>.

WHO Glossary. World Health Organization: Geneva. Available from: <http://www.who.int/hia/about/glos/en/>.

Wilkinson R, and Pickett K (2006). Income inequality and population health: a review and explanation of the evidence. *Social Science & Medicine* 62(7): 1768–1784.

Wilkinson R, and Pickett K (2010). *The spirit level. Why greater equality makes societies stronger*. New York: Bloomsbury Press.



Victorian Health Promotion Foundation
PO Box 154 Carlton South
Victoria 3053 Australia
T +61 3 9667 1333 F +61 3 9667 1375

vichealth@vichealth.vic.gov.au
vichealth.vic.gov.au
twitter.com/vichealth
facebook.com/vichealth

© VicHealth 2015
September 2015 P-EQ-265

VicHealth acknowledges
the support of the
Victorian Government.

