People, Places, Processes

Reducing health inequalities through balanced health promotion approaches

www.vichealth.vic.gov.au

VicHealth

Contents

VicHealth acknowledges the traditional owners of the country on which Melbourne stands, the Kulin Nations.

This document has been reviewed by staff of the Cochrane Collaboration to ensure that evidence used in this analysis is rigorous.

People, Places, Processes: Reducing health inequalities through balanced health approaches. Published for the web in April 2008 by the Victorian Health Promotion Foundation, 15-31 Pelham Street Carlton 3053. Telephone: 03 9667 1333.

For more information contact Mark Boyd
Senior Project Officer – Health Inequalities
Email:mboyd@vichealth.vic.gov.au
Web: www.vichealth.vic.gov.au/inequalities

Written by Mark Boyd, with the support and guidance of Jennifer Alden; Rebecca Armstrong; Kerry Haynes; Megan Kerr; Cristina Marras; Andrena Matthews; Jackie McCann; Philippa McLean; Tass Mousaferiadis; Barbara Mouy; Fiona Patterson; Jane Potter; Caroline Sheehan; Lee choon Siauw; Brian Vandenberg; Jackie Van Vugt; Irene Verins; Lyn Walker and Kim Webster.

Introduction

VicHealth
REDUCING HEALTH INEQUALITIES

This document provides an overview of current evidence from health promotion approaches, with the specific aim of analysing their potential to reduce health inequalities.

Efforts to reduce health inequalities are most likely to be effective when a coordinated range of mutually reinforcing strategies are targeted across varying levels of influence, including:

- **initiatives targeting under-resourced places;**
- **initiatives to improve individuals' socioeconomic position;**
- **broad-scale social marketing campaigns to shift relevant attitudes;**
- **initiatives to change health behaviours and community norms;**
- **improving how well we (as communities, organisations and workforces) take action to reduce inequalities;**
- **advocacy to secure community, government and corporate action; and**
- **reform of relevant policies and legislation.**

For effective action with limited resources, it is important for public health planners, the health promotion workforce and social policymakers to know when each approach is best able to achieve the goal of reducing health inequalities.

Purpose of this document

VicHealth applies a variety of health promotion approaches through its funding streams and research agenda, including methodological approaches that target the policy environment, community strengthening, personal skills development, organisational capacity and service delivery.

Following the development of the VicHealth *Position Statement on Health Inequalities,* determining the balance between focusing on the whole of the population, on disadvantaged communities or on the places in which they live was recognised as a key theme requiring further investigation, as emerging research could significantly inform the health promotion field's capacity to tackle health inequalities.

This document aims to guide those planning health promotion programs to design interventions that have the greatest potential to reduce health inequalities. This is done by using an equity lens (Part I) in program design and by choosing the most effective health promotion approach to achieve project goals (Part II).

The health inequalities agenda today

In Victoria, health inequalities policy faces a renewed focus across government, within academia and amongst the non-government/community sector.

Within the Victorian Government, a range of policy initiatives have the potential to reduce health inequalities. In particular there is:

- a renewed commitment to State-provided universal services, such as maternal and child health services, coupled with targeted interventions such as free kindergarten access for low income families (Department of Premier and Cabinet 2007b);

- a State Government-led national policy reform agenda which acknowledges the integral role of human capital and its goal of encouraging the full potential of all Australians (Department of Premier and Cabinet 2007a);
- several jurisdictions are acting to reduce inequalities in health and have adopted diverse approaches (Boyd & Trudinger 2007);
- a strong support base for place-based approaches to reduce disadvantage and a recognition of emerging needs and a committed focus on growth corridor areas to proactively influence new place development (Ministerial Advisory Committee for Victorian Communities 2006);
- continuing focus on addressing health inequalities through ongoing development of strategies targeting sub-population groups experiencing disadvantage (Department of Premier and Cabinet 2007b).

Within academia, a range of research programs have introduced a health inequalities dimension to current projects, and continued work by the Cochrane Collaboration's equity field group is fostering an equity lens focus amongst all research as a minimum standard (Robinson et al. 2005).

In 2007, professional associations, including the Australian Health Promotion Association and the Public Health Association of Australia and New Zealand, have focused on health equity as the theme of their annual conferences in order to share current learning. VicHealth is currently working with colleagues in other states and territories to develop an informal national network of health inequalities policy stakeholders from government, academia and the community.

Within Victorian community organisations, groundbreaking work has the capacity to deepen our understanding of health inequalities policy and interventions. In particular:

- Aboriginal community controlled organisations across the state support a range of initiatives to improve the social and economic position and consequent health status of our Indigenous communities.
- VicHealth supports the Victorian Health Inequalities Network which seeks to build collaborative, innovative responses across government, academia and the community sector.
- The Brotherhood of St Laurence is leading social research on intervening at those life transition points which increase vulnerability and entrench inequality.
- Victorian Foundation for Survivors of Torture, and other organisations working with people from varying cultural backgrounds, support a range of initiatives to improve refugee settlement experiences and reduce the potential health inequalities that are observable in current Victorian data.
- VicHealth-funded projects across local government, neighbourhood houses, sporting associations, arts groups and a wide range of other community groups all have varying degrees of capacity to impact on health inequalities.

Key findings from this project

Overall, this project has found:

- At times, there has been a merging of social policy goals that target disadvantage and that aim to reduce health inequalities. This is potentially detrimental to effective action and policy development, as these goals require separate (but complementary) approaches.
- There is a need to have a range of health promotion approaches, including place-based, whole-of-population, targeted sub-population interventions and life course approaches, to tackle health inequalities.
- Clear program logic will assist in identifying the most effective health promotion approach to be taken depending on the health promotion goal and can inform evaluation tasks in an efficient and effective manner. The equity triangle lens aims to foster an equity focus in program planning. This tool is currently being piloted within VicHealth, and with a number of Primary Care Partnerships.

Part I. The equity triangle lens

The VicHealth *Position Statement on Health Inequalities* identifies the following populations as facing the greatest inequality:

- Indigenous Victorians;
- Newly arrived migrants and refugees;
- People with disabilities;
- People with low socioeconomic backgrounds; and
- Children and young people living in low socioeconomic areas.

This tool is aimed at assisting community interventions and services to introduce a stronger focus of equity into planning, delivery and evaluation.

What do we mean by 'health inequality'?

Dimensions of inequality

Health inequalities are differences in health status (such as rates of illness and death or self-rated health) that result from social, economic, and geographic influences that are avoidable unfair and unnecessary (Victorian Health Promotion Foundation 2005).

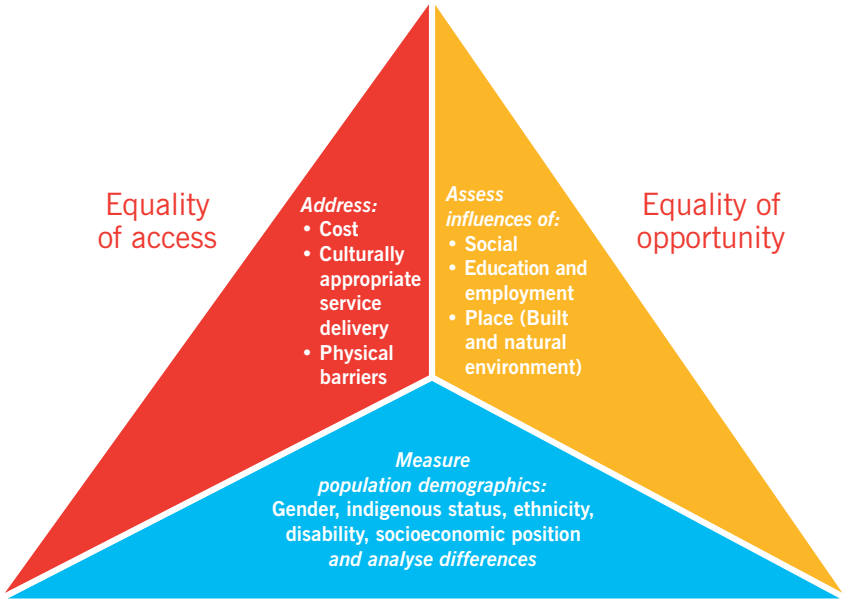
There are three dimensions to inequality:

- ***Inequality of access*** **refers to barriers to the services that support health and wellbeing. It includes barriers created through cost, through physically inaccessible services and through services not being culturally appropriate for all people living in Victoria.**
- ***Inequality of opportunity*** **refers to barriers to the social, geographic and economic resources necessary to achieve and maintain good health such as education, employment, income and a safe place to live.**
- ***Inequality of impacts and outcomes*** **refers to differences in health status between groups (for example in rates of death, illness or self-reported health). It is important to measure health outcomes so that it is possible to notice who is and who is not achieving good health and wellbeing in the community.**

Ensuring equality is about moving beyond equality of access (mainly understood as cost, cultural barriers such as language translation, physical modifications and culturally appropriate service delivery) to ensuring equality of opportunity (addressing economic, social, cultural and geographic influences) and measuring equality of impacts and outcomes (by collecting demographic data that analyses the different impacts for sub-populations facing inequality).

AUDIENCE: **Program managers designing health promotion interventions**
Team leaders and coordinators overseeing services, projects and programs

PURPOSE: **To introduce discussion of equity issues into program/service planning, delivery and evaluation.**



In partnership activities (and at the agency level) the equity triangle acts as a prompt to consider how to improve targeting of projects, programs and services to reduce inequalities.

The aim of the triangle is to introduce an equity dimension to program planning and delivery without this becoming a cumbersome process.

The checklist that follows provides some prompts to encourage equity-focused solutions. As a minimum in the short term, services and programs should address equality of access and equality of impacts and outcomes, and create partnerships (such as with local government or state advocacy organisations) to assist with addressing equality of opportunities.

This equity triangle tool and prompting questionnaire are currently in draft form and being trialled in the field, both within VicHealth and amongst the health promotion workforce. Consideration of its wider potential will be discussed following evaluation of this trial.

This equity triangle tool and prompting questionnaire are currently in draft form and being trialled in the field, both within VicHealth and amongst the health promotion workforce. Consideration of its wider potential will be discussed following evaluation of this trial.

Equity triangle lens

This equity tool and the prompting questionnaire below can be used at all stages of program delivery:

BEFORE: To aid in designing programs with a clear equity focus to reduce potential barriers to participation/access.

DURING: To enhance programs and reorient existing delivery to better meet the needs of sub-populations facing the greatest inequality.

AFTER: To critically reflect on the effectiveness of the program in addressing inequalities or to evaluate the impact of the program on marginalised/disadvantaged communities.

Equality of access: immediate barriers

Inequality of access refers to barriers to the services that support health and wellbeing. It includes barriers created by services being physically inaccessible and through services being culturally inappropriate for some people living in Victoria.

Prompting questions	Areas to follow these up
1 Cost	
1.1 Is there a cost involved in participating/accessing the program/project/service, including travel? Are there any costs involved in participating such as uniforms, books, tools?	
1.2 If there is a cost, is there a pricing policy/concession rate (or capacity to waive the fee) to ensure that those facing the greatest inequality are not further disenfranchised? What parking is available and is it free?	
1.3 Is there access to childcare? (Either provided or by ensuring partnerships and easy referral pathways?)	
1.4 Is there access to respite care? (Either provided or by ensuring partnerships and easy referral pathways?)	

Your notes on further action regarding section one:

Prompting questions	Areas to follow these up
2 Culturally appropriate service delivery	
2.1 In what ways will the focus population be involved in planning, delivery, participation and evaluation of the work?	
2.2 Has data been reviewed on the number of people in the project/service catchment area: with low socioeconomic status? Of Indigenous background? With a disability? Of non-English speaking, and particularly refugee, backgrounds (and from which countries in particular?)	
2.3 Have staff been trained in cultural security/diversity/respect and anti-racism?	
2.4 Are there regular opportunities to maintain and enhance training in cultural security/diversity/respect and anti-racism?	
2.5 What training is available for people involved in the program from reception intake/service access and what policies/procedures support inclusion in services?	
2.6 Are there policies and procedures to recognise the traditional owners at public events?	
2.7 How are Aboriginal and Torres Strait Islander peoples made to feel welcome?	
2.8 How are Aboriginal concepts of health incorporated into the program?	

This equity triangle tool and prompting questionnaire are currently in draft form and being trialled in the field, both within VicHealth and amongst the health promotion workforce. Consideration of its wider potential will be discussed following evaluation of this trial.

Prompting questions	Areas to follow these up
2.9 Are resources available in languages other than English? Do these reflect findings from the data review (question 2.2)?	
2.10 Are staff aware of how to access interpreter services, including Auslan? Are there policies and procedures to enable use of interpreter services, including tracking use? How do limitations to the use of interpreters inform advocacy for better service provision?	
2.11 How are new arrival communities engaged and what level of awareness do program managers/team leaders/coordinators have of these populations?	
2.12 How are people from culturally diverse backgrounds made to feel welcome?	
2.13 Have needs of both women and men been considered? Has the DHS gender equity tool been used?	
2.14 Have program workers thought creatively about how to break down gender stereotypes?	
2.15 Does the service/program have TTY access and electronic support such as enlarged documents on the internet?	
2.16 How does the program/activity support the needs of the children of participants? If a service, are children's needs assessed separately to their presenting parent(s)?	
2.17 How does the program/activity support the needs of carers of participants? If a service, are carer's needs assessed separately to service users?	

Prompting questions	Areas to follow these up
3 Physical barriers	
3.1 Are resources available in large print?	
3.2 Is language clear and in plain English?	
3.3 Are venue layout and scheduled times of activities accessible for people with vision impairment and/or limited mobility?	
3.4 Are project staff aware of how to access: • taxi subsidy support services? • aids and equipment financial support? Are there policies and procedures to train staff in use of supports?	
3.5 Have transport routes been mapped to ensure access is possible? Does the program venue encourage diverse and socially excluded groups to gather and mix with others through the provision of such things as disability parking, seating, walking and bicycle tracks, bicycle parking capacity and parking facilities that are free or low-cost?	
3.6 Can alternative transport be provided?	

Your notes on further action regarding sections two & three:

This equity triangle tool and prompting questionnaire are currently in draft form and being trialled in the field, both within VicHealth and amongst the health promotion workforce. Consideration of its wider potential will be discussed following evaluation of this trial.

Equality of opportunity: Building opportunities for life

Inequality of opportunity refers to barriers to the social, geographic and economic resources necessary to achieve and maintain good health, such as education, employment, income and a safe place to live.

Prompting questions	Areas to follow these up
4 Place (built/natural environment) influences	
4.1 Is consideration given to the perceptions of the venues' safety by participants through such things as efficient lighting, enhanced use by diverse groups, safe walking paths, and lack of vandalism, graffiti and litter?	
4.2 What are the levels of housing affordability in the program/project/service catchment area? (Households paying more than 30% of their income on housing are considered to be in housing stress.)	
4.3 Is there data on the number of private renters and public tenants in the program/project/service catchment area? How are these residents engaged?	
4.4 How accessible are the local transport and walking routes for residents in the program/project/service catchment area?	
4.5 Is there a high outlet density of places that sell tobacco, alcohol and fast food? Is there local access to fresh fruit and vegetables?	
4.6 Are there local community centres and other areas for people to come together collectively?	
4.7 How can stresses on transport, housing and the business/community mix be addressed through the program/project/service?	

Your notes on further action regarding section four:

Prompting questions	Areas to follow these up
5 Education and employment influences	
5.1 Does the program/project/service offer opportunities for participants to improve their own reading, numeracy and other skills through program activities?	
5.2 Are program/project/service staff aware of referrals for: Social security payments advice, housing support, community banking and financial counselling?	
5.3 Does the program/project/service develop skills that increase the opportunities for participants to access education and employment opportunities, including referral pathways and by developing partnerships and alliances?	
5.4 Does the program/project/service make explicit links between the activities provided and job readiness and potential education and employment opportunities?	
5.5 Does the program/project/service address barriers that participants may have to education and employment opportunities?	
5.6 Are there ways the program/project/service can generate new income for participants or reduce the current income participants would spend?	
5.7 Does the organisation practise healthy workplace policies such as: control over conditions experienced by workers, diversity within the workforce, offering appropriate reward for effort, reducing workplace stress, and reducing the size of income differentials between staff?	
5.8 Are there longer-term opportunities to hire program/project/service participants and other low-income people?	

Your notes on further action regarding section five:

This equity triangle tool and prompting questionnaire are currently in draft form and being trialled in the field, both within VicHealth and amongst the health promotion workforce. Consideration of its wider potential will be discussed following evaluation of this trial.

Prompting questions	Areas to follow these up
6 Social influences	
6.1 How are people made to feel welcome?	
6.2 Does the program increase participants' access and participation in broader social networks?	
6.3 How are new program/service users inducted?	
6.4 Do program activities provide opportunities for participants to mix and work in partnership with people of all ages, people with disabilities, migrants, Indigenous people and people with varying socioeconomic position and work status, including those with secure incomes and employment?	

Your notes on further action regarding section six:

Equality of impacts and outcomes: Measuring and sharing success

Inequality of impacts and outcomes refers to the differences in health status between groups (for example, in rates of death, illness or self-reported health). It is important to measure health outcomes so that it is possible to notice who is and who is not achieving good health and wellbeing in the community.

Prompting questions	Areas to follow these up
7 Evaluation and dissemination	
7.1 Are statistics collected and used in planning which can be measured by: • Gender • Ethnicity • Indigenous status • Disability • A measure of socioeconomic position	
7.2 Do evaluation activities ensure results are analysed by the following population demographics: • Gender • Ethnicity • Indigenous status • Disability • A measure of socioeconomic position	
7.3 Are results compared against total figures or a local average in order to determine if outcomes are different for sub-populations facing the greatest inequality?	
7.4 How will the program show ongoing benefits for participants and maintain community and partner commitment?	
7.5 How do you plan to disseminate the successful strategies?	

Your notes on further action regarding section seven:

This equity tool has been created using :

- learning from equity-focused health impact assessment processes
- learnings from equity audit cycle UK (www.avon.nhs.uk/phnet/Publications/hea/hea_seminar_presentation.ppt)
- Equity questions suggested from Upper Hume PCP
- VicHealth planning, monitoring and evaluating mental health promotion tool (www.vichealth.vic.gov.au)
- NSW Four Steps towards equity tool (www.health.nsw.gov.au/pubs/f/pdf/4-steps-towards-equity.pdf)
- How our programs affect population health determinants: A workbook for better planning and accountability, Health Canada (www.phac-aspc.gc.ca/ph-sp/phdd/pdf/progphd_work_e.pdf)
- Environments for Health Framework (www.health.vic.gov.au/localgov/mphpfr/index.htm#download).

Part II. Balancing health promotion approaches

VicHealth
REDUCING HEALTH INEQUALITIES

Health promotion offers opportunities to design multi-faceted programs to improve health and reduce health inequalities. In addition to the variety of action areas that can be targeted (policy, environments, community strengthening, personal skills, service delivery), approaches may focus on the whole population, sub-populations, at different points on the life course, and/or on the places in which people live.

Place-based approaches (or area-based initiatives) seek to improve the social, cultural, economic and/or physical environment within a defined boundary, in order to improve overall health and reduce the differences in health amongst the people living within that area (Baum et al. 2007; Klein 2004; Thomson et al. 2007).

Population-wide approaches target the whole of the population through:

- interventions (such as through health information social marketing campaigns);
- structural mechanisms and macroeconomic policies (such as the provision of public housing or through tobacco taxation); or
- by intervening to address the causes of ill health (such as provision of free education for all citizens) (Whitehead 2007).

Targeted sub-population interventions focus on populations that face particular disadvantage. VicHealth's *Position Statement on Health Inequalities (2005)* identifies a number of sub-populations of Victorians who face greater health and social inequalities. Indigenous Victorians, new arrival/refugee communities, people with disabilities and people on low incomes have been identified as key sub-populations that have poorer health in Victoria. Some approaches would seek to prioritise these groups for additional support, working in culturally appropriate, participatory ways.

Life course approaches recognise that certain stages of life give rise to health inequalities (Asthana & Halliday 2006), and are thus points for intervention to reduce health inequalities.

Place-based approaches

Place-based approaches (or area-based initiatives) seek to improve the social, cultural, economic and/or physical environment within a defined boundary, in order to improve overall health and reduce the differences in health among the people living within that area (Baum et al. 2007; Klein 2004; Thomson et al. 2006).

There is consistent evidence that place has an independent effect on health (Turrell et al. 2007a). In Australia, policies – including economic rationalisation, restructuring and closure of manufacturing industries, and public housing planning policies – have all contributed to concentrated pockets of people on low incomes living in the one area (Klein 2004). This concentration appears to compound determinants of health such as educational attainment, or occupation, and is associated with health-damaging behaviours and health attitudes (Kavanagh et al. 2007).

In Victoria, it is possible to use socioeconomic indices in conjunction with life expectancy and self-reported health (amongst other indicators) to demonstrate a fairly consistent association between low socioeconomic areas and poorer health outcomes for local populations (Kavanagh et al. 2005; McCracken 2001). This has led to a strong policy interest in reducing area-level impacts on individual health as a strategy to reduce health inequalities (Klein 2004; Ministerial Advisory Committee for Victorian Communities 2006).

Many of the influences on health occur in the settings in which we live our day-to-day lives, such as our homes, schools, communities and workplaces. Place-based approaches use the setting of a local area in which to carry out health promotion intervention activities.

CASE STUDY: Responding to health inequalities: investigating the impact of Neighbourhood Renewal on health and wellbeing in disadvantaged Victorian communities

Narrowing the gap in health inequalities is a key objective of the Victorian Government's Neighbourhood Renewal Strategy. Neighbourhood Renewal is currently being undertaken in 19 of the state's most socioeconomically disadvantaged neighbourhoods.

Significantly, the concentration of socioeconomic and other disadvantages in particular places is likely to generate additional health-related risks, over and above those linked to circumstances of household disadvantage. This happens for a number of reasons. There can be difficulties in accessing health-related services and resources where there is a dearth of private facilities and high demand on available public services. An emerging body of work is finding that aspects of physical and social environments in impoverished neighbourhoods appear to influence health-related processes. Physical disorders (for example, neglected properties and derelict buildings, vandalism, rubbish and graffiti) and social incivilities (such as public drinking or drug use, conflict, evident criminality and dangerous driving) appear to influence health-related processes in interconnected ways. Disorders and incivilities undermine residents' sense of wellbeing and safety. This may produce stress responses and physiological reactions that impair the immune system and heighten susceptibility to disease.

Data gathered from community surveys that are regularly undertaken at each of the Neighbourhood Renewal sites (300 surveys at each site) are lending support to evidence that physical disorders and social incivilities in neighbourhood environments may be influencing health-related processes. Analysis of aggregated data from 13 sites shows that residents who rated their neighbourhood as

'poor' were also more likely to rate their health as 'fair' or 'poor'. Place-based approaches enable health promotion to be embedded in everyday settings that support the kind of coordinated responses that are necessary for tackling the complex and interrelated issues that generate health inequalities.

The value of taking place-based approaches is evident in the achievements of NR projects. Working co-operatively with local partners, interlinked projects are working to promote access to resources and facilities, improve physical environments, enhance social goods (such as a sense of safety and security), and facilitate participation in decision-making processes.

Written by Deb Warr, a VicHealth Senior Research Fellow at the McCaughey Centre (VicHealth Centre for Mental Health and Community Wellbeing, University of Melbourne). This evaluation was undertaken as part of a Department of Human Services Public Health Research Grant.

Place-based approaches can focus on all or some of the people living within an area (compositional approaches) or can focus on the area's physical environment (contextual approaches) (Baum et al. 2007; Kavanagh et al. 2007; Kawachi & Subramanian 2007; Macintyre et al. 2002).

Place-based approaches in current Victorian policy target areas of concentrated disadvantage (Department of Premier and Cabinet 2007b), but low-income earners are spread widely across Victoria and do not only live in these areas of concentrated disadvantage (Randolph & Holloway 2007; Stanley et al. 2007).

Differences in definitions of place can increase or decrease how much an impact we think place may have on individual lives. A place usually ranges from a neighbourhood to a local government area (which differ considerably in size and population density). Thus, place-based interventions may use varying definitions or size boundaries for place when planning health promotion activities. Research evidence is similarly difficult to synthesise as different studies use different geographical boundaries when defining place. For example, when analysing the impact of place on health inequalities, research for this document has considered evidence from New Zealand district analyses (21 districts of varying size and population density) (Tobias & Searle 2006) and Victorian research which compared compositional and contextual elements in 50 census collector districts (each an average of 557 residents within a .34 km^2 radius) (Kavanagh et al. 2007).

Another ambiguity clouding our understanding of place-based approaches is the often-confused interchangeability of the terms 'community' and 'place' when discussing interventions aimed at improving health overall or reducing health inequality (Ziller 2004). The term community is avoided in this document as it could mean a geographic community (where people's sense of community is linked to their local area, such as a neighbourhood), a community of interest (such as the sense of community amongst a sports club, those with a common hobby or people within a workplace) or a community of attachment (such as the sense of community felt with family and kinship bonds) (Ziller 2004). However, 'community strengthening' approaches are recognised as a type of place-based approach, as they often use place to define the boundaries of the 'community' in which activities occur (Ministerial Advisory Committee for Victorian Communities 2006; Wiseman 2006).

Benefits of place-based approaches to reducing health inequalities

- While not addressing macroeconomic conditions, places are crucial settings for building self-confidence, self-efficacy and a sense of wellbeing that may lay the foundations for bridging networks (which link people of different socioeconomic status within an area) in the future (Warr 2005).
- Local approaches have assisted with renewing interest in community development and have fostered debate on social connectedness (Wiseman 2006).
- Area-based approaches may allow for efficiency in resource allocation, opportunities to focus activity and encourage a bottom-up approach (Klein 2004; Lupton 2003).
- Place-based approaches seem to work best "on some health outcomes, in some population groups, and in some types of areas" (Macintyre et al. 2002). For instance, the degree of people's economic activity or their level of transport advantage may influence their reliance on the local environment (Parkes & Kearns 2006).
- Place-based approaches may be most valuable coupled with a transitional/life course approach (Lupton 2003; Parkes & Kearns 2006; Ziller 2004) that target people who are most reliant on the local environment, including:
  - Mothers with young children
  - Unemployed people
  - Older people.
- VicLANES findings (Kavanagh et al. 2007) and the Heart Foundation's SESAW Study (Ball et al. 2005) suggest a range of contextual influences that 'place' may have on physical activity goals (including street connectivity and aesthetics), and on health behaviours (such as greater access to fast food and alcohol outlets in low income areas).
- Giskes, et al (2006) found that living in low socioeconomic areas had a separate and independent effect on increased smoking behaviour, but the causal pathway was still unclear.

Limitations of place-based approaches to reducing health inequalities

- International research (using varying methodologies) found that geographic variation accounts for between 8% and 11% of the health inequalities gap (Oreopoulos 2005; Tobias & Searle 2006; Wagstaff et al. 2001).
- Local evidence suggests that there is equivalent access to community resources (fresh fruit and vegetable stores, and recreation facilities) across neighbourhoods regardless of socioeconomic status (although quality and affordability were not measured) (Kavanagh et al. 2007; Pearce et al. 2007).
- Interventions focusing on area disadvantage can lead to stigma and blame for residents living in those areas (Mowbray 2004; Warr 2005).
- Policy analysts argue that health inequalities "are perpetuated by systemic processes that operate outside targeted places" (Carson et al. 2007; Pappas 2006).
- Local urban planning policy has yet to incorporate goals aimed at altering the socioeconomic composition of areas to minimise the peer effects of concentrated poverty by promoting greater social mix, by addressing urban planning income enclaves, or by promoting affordable housing (Lupton 2003; Ziller 2006).
- There is little evidence internationally that place-based approaches – such as urban renewal initiatives – can impact on inequalities that are more often rooted in macroeconomic causes (Thomson et al. 2006).

Population-wide approaches

VicHealth
REDUCING HEALTH INEQUALITIES

Population-wide approaches target the whole of the population through:

- **interventions targeting individual behaviour (such as through health information social marketing campaigns);**
- **structural mechanisms and macroeconomic policies (such as the provision of public housing or through tobacco taxation); or**
- **interventions addressing the causes of ill health (for example by providing free education to all citizens) (Whitehead 2007).**

In Whitehead's typology of actions to reduce health inequalities (2007), interventions targeting individual behaviour describe the *social marketing and large-scale health information-type messages* such as the QUIT media campaigns, and VicHealth's Official Supporter campaign. If everyone changes their behaviour even a little, this can add up to sizeable benefits for the whole of the population (Rose 2001).

There is some proven effectiveness for these campaigns in inspiring short-term behaviour change and they reach a wide audience (Burns 2007; Wakefield 2007). This can have an impact on health inequalities by reducing the burden of disease on the whole of the population, including those most disadvantaged (i.e. an "absolute" reduction) (Lynch et al. 2007).

However, people with the most resources/income to take up the health promotion message may achieve the most benefit, with a more moderate benefit for middle income earners. Those on the lowest incomes may not have the choice or may have other pressures which outweigh perceived benefits and are less able to change behaviour. This can widen inequalities when comparing the most disadvantaged with the most advantaged (i.e. "relative inequality") (Graham & Kelly 2004; LaMontagne et al. 2006; Whitehead 2007; Whitehead & Dahlgren 2006).

Structural mechanisms and macroeconomic policies overlap in some ways with causal approaches that seek to ensure universal access to the key resources for health for everyone in a society. They often represent a midstream intervention point, such as tobacco taxation or public housing provision. They are interventions at the population-wide level but do not necessarily affect the whole of the population. Tobacco taxation creates improvements for health in large numbers of people, including those from a low socioeconomic background, by deterring use through pricing mechanisms (Alcohol and Other Drugs Council of Australia 2003). Price can be a driver for smoking cessation, regardless of income (Graham et al. 2006).

However, workplace stress studies suggest that workers in jobs with low control and high stress have much higher smoking rates, suggesting that this psychosocial environment may override an individual's capacity to stop smoking (LaMontagne et al. 2006). This indicates a possible 'tipping point' in population-wide interventions that may inadvertently increase inequalities, where price increases simply add to the financial burden for low-income earners. The lack of equity-focused health impact assessment of public policy (Harris et al. 2007) limits the evidence base analysing the potential negative impacts of structural and macroeconomic policies in reducing health inequalities.

A *casual approach* allows a focus on addressing unequal access to the material resources necessary for good health such as good housing, adequate income and secure, safe working conditions (Bryant et al. 2007; Graham et al. 2006; Graham & Kelly 2004; Raphael 2006a, b; Raphael & Bryant 2006; Whitehead 2007; Whitehead & Dahlgren 2006). This focus is of particular importance as it also reduces the need for specifically designed behaviour modification approaches to support individuals to cope with unhealthy environments.

The provision of universal programs is an example of an upstream approach to reducing health inequalities. Korpi and Palme (1998) found that the provision of universal programs such as access to health care and education for all resulted in less income inequalities within a society, lower rates of poverty and greater redistribution of resources across a society. Such research has led many health policymakers to focus on the issue of universal access to these causes of health such as: secure, affordable and appropriate housing; access to healthy foods; education; and employment. These are key intervention points in order to reduce health inequalities (Baum et al. 2007; Bryant et al. 2007; Graham & Kelly 2004; Navarro 2007; Raphael 2006a, b; Raphael & Bryant 2006; Whitehead 2007; Wilkinson & Marmot 2003).

However, there is not always consensus on how these influences impact on individual health, and therefore where best to intervene. In the past, this has led to a "mental block" (Whitehead 1998) that has prevented a proactive research agenda – including in Australia – to intervene successfully at a causal level (Newman et al. 2006). Further, researchers have noted their frustration (internal feedback, 2005) at a research system that discourages independent evaluation of interventions as too costly. This inhibits our understanding of how to effectively take action on the causes of ill health at a population-wide level to reduce health inequalities. Also, the design of social intervention research trials can involve a range of ethical, financial and validity concerns (Petticrew 2007; Thomson et al. 2004) that largely inhibits their potential to provide solid evidence to policymakers.

Benefits of population-wide approaches to reducing health inequalities

- Social interventions targeting individual behaviour can be easy to implement (such as social marketing messages), and confer some success while broadcasting, and are most effective when complemented by a mix of focused community activities and when used over time (Keleher & Armstrong 2005).
- Provision of universal programs such as access to health care and education for all can result in less income inequalities within a society, lower rates of poverty and greater redistribution of resources across a society. This has led many health policymakers to focus on universal access to the determinants of health such as secure, affordable and appropriate housing; access to healthy foods; education; and employment as key intervention points in order to reduce health inequalities (Baum et al. 2007; Bryant et al. 2007; Graham & Kelly 2004; Navarro 2007; Raphael 2006a; b; Raphael & Bryant 2006; Whitehead 2007; Wilkinson & Marmot 2003).
- Focusing on casual approaches can produce sizeable results in reducing health inequalities when applied creatively and rigorously, such as in housing improvements as tested in New Zealand (Howden-Chapmen et al. 2007; Thomson & Petticrew 2007).
- There appears to be apparent effectiveness in reducing health inequalities through national industrial, employment, housing and family policies in New Zealand (Ministry of Health & University of Otago 2007).
- A focus on the causes of ill health can be more efficient in promoting good health and community wellbeing (Baum et al. 2007; Graham & Kelly 2004).
- Causes of good health such as accessible education systems "have a large part to play in breaking the link between childhood and adult disadvantage" (Graham et al. 2006).

Limitations of population-wide approaches to reducing health inequalities

- There is not always clear consensus on the causal pathways for these influences and therefore a lack of agreement on appropriate intervention points (Lynch et al. 2007).
- There is limited evidence on effective, robust trials of social interventions at a population-wide level (Petticrew 2007; Thomson et al. 2004).
- Population-wide approaches can inadvertently widen inequalities as uptake can be higher amongst more well-resourced community members (Draper et al. 2004; LaMontagne et al. 2006; Turrell et al. 2006).
- As the economic and social resources for health lie outside the health system and involve many stakeholders, there is often resistance in the current neo-liberal political context, as there is not always consensus on the trade-offs necessary to take effective action to reduce health inequalities (Catford 2007).
- Population-wide approaches, particularly those that are focused on the underlying causes, require long-term commitment which creates difficulties in maintaining political will within three-year election cycles (Catford 2007; Newman et al. 2006).

Targeted sub-population interventions

Targeted sub-population interventions focus on populations that face particular disadvantage. VicHealth's *Position Statement on Health Inequalities* identifies a number of sub-populations of people living in Victoria who consistently experience poorer health outcomes. Indigenous Victorians, new arrival/refugee communities, people with disabilities, and people on low incomes have been identified as key sub-populations that have poorer health in Victoria.

There are different influences that impact on each of these sub-populations to create or entrench health inequalities.

For Indigenous Victorians, despite cultural strengths such as respect for elders, extended and supportive family networks, and a concept of health that incorporates connection with spirit and land, entrenched disadvantage across generations has been caused by structural problems and race-based discrimination since colonisation (Carson et al. 2007; Pulver et al. 2007). An overview of existing global knowledge on the social determinants of Indigenous people acknowledges the loss of land and marginalisation of Australian Aboriginal people (Anderson 2007; Pulver et al. 2007). This is accompanied by individual and institutional experiences of discrimination, which place burdens of stress, alienation and loss of control on many individuals, families and communities (Paradies 2007). Researchers have noted that "The strong and complex interrelatedness of individual behaviour, material deprivation and the psychosocial stressors is poorly understood, especially as they play out across generations and within the Aboriginal conception of health which is holistic and strongly linked to community well-being as well as individual health status" (Pulver et al. 2007).

For new arrival and refugee communities, both interpersonal and institutional culture-based discrimination contribute to the burden of disease by limiting access to the socioeconomic resources necessary to build a healthy life in Australia (Boyd 2007; VicHealth 2007). In addition, the impact of war, the often traumatic and disruptive refugee experience, accreditation systems that do not recognise some qualifications, and being perceived as labour market competition in some areas with high blue-collar employees, have all been demonstrated to impact on health inequities for this sub-population (VicHealth 2007).

For refugees from some non-English speaking countries, this entrenched disadvantage is not ameliorated by longer settlement in Australia. Migrants from the Horn of Africa, the Middle East and Lebanon, and Vietnam have consistently lower employment and community participation rates than others with similar lengths of settlement in Australia (Colic-Peisker & Tilbury 2007; Ho & Alcorso 2004).

CASE STUDY: *Ambassador* newspaper

The *Ambassador* - run by the Horn of Africa Communities Network – is a monthly newspaper produced in five to eight African languages by refugee and new-arrival volunteers and staff. Over the years, volunteers have learnt skills in writing, production, management and marketing. The paper is vital to building a community for an audience facing many social and economic challenges in establishing a new life in Victoria.

To subscribe to the *Ambassador*, or to find out more, contact: hacn@bigpond.net.au

For people with disabilities, the physical barriers, discrimination and cultural attitudes they encounter all limit full participation in community life, which acts to maintain unequal health outcomes (Australian Bureau of Statistics 2007; Kisely et al. 2007; Victorian Health Promotion Foundation 2005).

For people on low incomes, lack of access to economic resources (housing, education, job security) requires new social policies in employment, housing and education and stronger investment in social housing (Howe 2007). People on low incomes live across Victoria (Stanley et al. 2007) – not just in concentrated areas of disadvantage – and in some cases those living in areas of higher advantage face greater housing stress (Australian Housing and Urban Research Institute 2007).

Targeted sub-population approaches seeking to intervene in some of these causes of inequality may be the most efficient goal.

At times, targeted sub-population interventions emphasise action directed at the sub-population groups themselves at the expense of changing wider cultural and societal norms that entrench inequalities. For example, some of the cultural attitudes held by the wider, mainstream community entrench health inequalities for Indigenous Victorians and refugee sub-populations. Interventions may seek to address the aspects of race-based discrimination amongst the wider community rather than targeting sub-populations directly (Forrest & Dunn 2007).

Benefits of targeted sub-population interventions in reducing health inequalities

- Targeted approaches can act on equity of access issues such as culturally secure service delivery ('cultural security' refers to accessible quality services available to all even if one's values/beliefs are different to the service delivery system; (see Houston 2007)) and physical modifications to ensure a minimum standard of best practice health promotion activity to reduce inequality (Tobias & Peh 2007).
- Social interventions can be effective in improving health outcomes for participants from targeted sub-populations (Thomson et al 2004).
- Targeted sub-population approaches can be used in conjunction with place-based approaches to respond to local variations in community attitudes to race-based discrimination (Dunn & McDonald 2001; VicHealth 2007).
- These approaches also often involve community development approaches that have multiple benefits including self-confidence, skills development and social connectedness (Warr 2005).

Limitations of targeted sub-population interventions in reducing health inequalities

- Targeted approaches can be more expensive and require a wider range of community engagement strategies (Keleher & Armstrong 2005).
- These approaches can be slower than population-wide approaches at creating health gains, as often disadvantage is cumulative and reduces the size of any one intervention's impact (Lynch et al 2007).
- Interventions focusing on sub-population disadvantage can lead to stigma and blame for those particular communities (Warr 2005, Mowbray 2004).
- Community perceptions of targeted resourcing to sub-populations can be met with resistant community attitudes that deny the privileged cultural position of Anglo-Celtic/White Australians (Dunn & McDonald 2004).

Life course approaches

Each period of the life course has certain pathways and processes that can give rise to health inequalities (Asthana & Halliday 2006).

People are at greater risk of facing inequality at key transition points in the life course: "During such periods as entry into parenthood and the transitions from the parental home to the outside world, from school to work, from one job to another, and into retirement, levels of income support and availability of publicly funded services influence the degree of insecurity and uncertainty experienced by individuals and families" (Bartley et al. 1997). In Victoria, the Brotherhood of St Laurence focuses on key transition points in order to assist policy development aimed at reducing social inequalities. Similarly, recent policy approaches described by Brian Howe in *Weighing Up Australian Values* (2007) point to the potential of life course approaches that seek to minimise the risks that occur during these transitional life stages as offering a new era in social policy development.

The VicHealth *Position Statement on Health Inequalities* (2005) notes:

Interventions to address health inequalities should recognise that the relationship between social and economic inequalities and health inequalities is complex, and results from the influence of material, psychosocial and behavioural factors over a lifetime and across generations.

Early life experiences have a key impact on an individual's lifetime health and social outcomes. At an individual health level, stress and nutrition in early years can have a marked impact on brain development (Moore 2006b). Social inequalities also impact on health and act cumulatively over a lifetime to entrench health inequalities (Prus 2007; Turrell et al. 2007b). This suggests that an early life focus could be an efficient approach to reduce accumulation of disadvantage over a lifetime (Graham et al. 2006).

It is possible to take both a sub-population and life course focus to health promotion activities. For example, a review of Australian child and youth health inequalities conducted in 2003/04 found that amid widespread improvements, "the elevated rates of mortality for children and young people of Indigenous origin are a cause for considerable concern, as are the mortality inequalities associated with accidental deaths, particularly male suicide, for rural and remote children and young people" (Nicholson et al. 2004). This suggests both targeted sub-population and life course interventions may be a direction to pursue to reduce these health inequalities.

CASE STUDY: Mental health and wellbeing of children from low-income families

This VicHealth-funded research program aims to build understanding of children's mental health, focusing on child health inequalities. This will include the identification of the key determinants of mental health for preschool children from low socioeconomic families, and the development and trial of community-based mental health promotion interventions for these children and their parents.

For further details, contact the McCaughey Centre via their website: www.mccaugheycentre.unimelb.edu.au/

Benefits of life course approaches to reduce health inequalities

- Life course approaches lead to improved psychosocial and health outcomes in the long term;
- Life course approaches are particularly effective with children from disadvantaged backgrounds; and
- The earlier the intervention begins (and the longer it lasts), the more effective it is likely to be (Moore 2006b).

Limitations of life course approaches to reduce health inequalities

- Evidence reviewed indicates the need to develop life course approaches in combination with a wider causal lens. In particular:

  Interventions need to address multiple environmental risk factors simultaneously rather than focusing on single issues – intervention programs that address a single aspect of child and family functioning are likely to fail by ignoring other factors that can undermine family functioning and child development (Moore 2006b).

- Life course impacts begin before birth and therefore also require a supportive environment and intervention at a causal level to be effective (Asthana & Halliday 2006).

Multi-faceted program design

Most researchers and policy makers acknowledge the need for multi-faceted program design. Researchers reviewing children and young people's health inequalities, for example, warn against solely focusing on early development. The authors note that "attempts to reduce health inequalities will only be effective through the development of linked-up solutions offered across the life course, which involve actions across multiple jurisdictions and professional groups in partnership with communities (Nicholson et al 2004)".

Efforts to reduce health inequalities are most likely to be effective when a coordinated range of mutually reinforcing strategies are targeted across these levels of influence, including:

- initiatives targeting under-resourced places;
- initiatives to change individuals' socioeconomic position;
- broad-scale social marketing campaigns to shift relevant attitudes;
- initiatives addressing health behaviours and community norms;
- improving how well communities, organisations and workforces take action to reduce inequalities;
- advocacy to secure community, government and corporate action: and
- reform of relevant policies and legislation.

Many of the factors that entrench inequalities cross boundaries traditionally existing between government departments, disciplines and settings, and between the government and non-government sectors. Thus a multi-level, cross-sector, cross-discipline approach is required.

Settings-based approaches

Many of the influences on health occur in the settings in which we live our day-to-day lives, such as our homes, schools, communities and workplaces.

A settings-based approach is useful when overlayed or used in conjunction with place-based, population-wide, targeted and life course approaches.

CASE STUDY: Workplace health promotion

VicHealth-funded research by Tony LaMontagne (La Montagne et al 2006) found strong occupational influences on cardiovascular disease risk amongst men and depression and anxiety prevalence amongst women, and evidence of the effectiveness of workplace settings-based health promotion interventions.

Thus, a program logic may choose to target industrial relations policy at an industry or national level as well as encourage social marketing and behaviour-change interventions in occupational settings targeting relevant workers. While place may not be a factor in program design at all, it may be worth reviewing additional place impacts on health when designing these programs – for example, do workers in such industries have accessible transport? Are industries clustered in particular areas?

References

Alcohol and Other Drugs Council of Australia 2003, *'Position Paper: Alcohol'*, Alcohol and Other Drugs Council of Australia.

Anderson, I. 2007, 'Indigenous Health: Politics, Rhetoric or Reality Check?' in *38th Annual Conference: Reality Check,* Public Health Association of Australia and New Zealand, Alice Springs.

Asthana, S. & Halliday, J. 2006, *What works in tackling health inequalities? Pathways, policies and practice through the lifecourse,* Policy Press, Bristol.

Australian Bureau of Statistics 2007, '*General Social Survey, Victoria, 2006*', Australian Bureau of Statistics.

Australian Housing and Urban Research Institute 2007, 'Where do low-income private renters live?' in *AHURI Research & Policy Bulletin*, Australian Housing and Research Institute, Melbourne.

Ball, K., Crawford, D., Salmon, J., Timperio, A., Giles-Corti, B. & Mishra, G. 2005, "*SESAW" Study: Socioeconomic and neighbourhood inequalities in women's physical activity, diet and obesity: Summary report*, Deakin University & National Heart Foundation.

Bartley, M., Blane, D. & Montgomery, S. 1997, 'Socioeconomic determinants of health: Health and the life course; why safety nets matter', *British Medical Journal*, vol. 314, p. 1194.

Baum, F., Ziersch, A., Zhang, G., Putland, C., Palmer, C., MacDougall, C., O'Dwyer, L. & Coveney, J. 2007, '*People and Places: Urban Location, Social Capital and Health',* Australian Health Inequities Program, Flinders University.

Boyd, M. 2007, 'Living in a culture of Anglo dominance', *VicHealth Letter,* no. 30.

Boyd, M. & Trudinger, D. 2007, 'State policies to address health inequalities: Towards good practice', in *Reality Check: Public Health Association of Australia and New Zealand Conference 2007,* Alice Springs Convention Centre.

Bryant, T., Raphael, D. & Travers, R. 2007, 'Identifying and strengthening the structural roots of urban health in Canada: participatory policy research and the urban health agenda', *Promot Educ,* vol. 14, no. 1, pp. 6-11.

Burns, D. 2007, 'Californian perspective on anti-smoking campaigns', in T*obacco Control: Where to from here? A collaborative forum for DHS, VicHealth, Quit and VicHealth Centre for Tobacco Control staff,* VicHealth.

Carson, B., Dunbar, T., Chenhall, R. D. & Bailie, R. (eds) 2007, *Social Determinants of Indigenous Health,* Menzies School of Health Research.

Catford, J. 2007, 'Grass Roots to Global Action: Health Promotion in Challenging Environments: Opening Address', in *Grass Roots to Global Action: Health Promotion in Challenging Environments*, Adelaide Convention Centre.

Centre for Parenting and Research 2006, *'Seminar Notes: Early Years Program Evaluation: the UK evidence base'*, NSW Department of Community Services.

Colic-Peisker, V. & Tilbury, F. 2007, *'Refugees and Employment: The effect of visible difference on discrimination'*, Murdoch University.

Department of Premier and Cabinet 2007a, *'Council Of Australian Governments' National Reform Agenda: Victoria 's Plan To Address The Growing Impact Of Obesity And Type 2 Diabetes'*, Victorian Government.

Department of Premier and Cabinet 2007b, '*A Fairer Victoria: Building on our commitment'*, Victorian Government, Melbourne.

Draper, G., Turrell, G. & Oldenburg, B. 2004, *Health Inequalities in Australia: Mortality. Health Inequalities,* Queensland University of Technology, Australian Institute of Health and Welfare, Canberra.

Dunn, K. M. & McDonald, A. (2001). 'The geography of racisms in NSW: A theoretical exploration and some preliminary findings', *Australian Geographer,* vol. 32, pp. 29-44.

Dunn, K.M. & McDonald, A. (2004). Constructing racism in Australia', *Australian Journal of Social Issues*, Vol 39, pp.409-30.

Forrest, J. & Dunn, K. 2007, *'Strangers in our midst? Intolerance and dioscrimination towards minority cultural groups in Victoria'*, Geographies of Racism Project, University of New South Wales. Report to VicHealth.

Giskes, K., van Lenthe, F. J., Turrell, G., Brug, J. & Mackenbach, J. P. 2006, 'Smokers living in deprived areas are less likely to quit: a longitudinal follow-up', *Tob Control,* vol. 15, no. 6, pp. 485-8.

Graham, H., Francis, B., Inskip, H. M. & Harman, J. 2006, 'Socioeconomic lifecourse influences on women's smoking status in early adulthood', *J Epidemiol Community Health,* vol. 60, no. 3, pp. 228-33.

Graham, H. & Kelly, M. P. 2004, '*Briefing paper – Health inequalities: concepts, frameworks and policy'*, NHS Health Development Agency.

Harris, P., Trudinger, D. & Piontek-Walker, H. 2007, 'Health Impact Assessment: Building capacity towards addressing the social determinants of health and health inequalities in Victoria and New South Wales', in *Grass Roots to Global Action: Health Promotion in Challenging Environments, 17th national Conference,* Australian Health Promotion Conference, Adelaide Convention Centre, p. 105.

Ho, C. & Alcorso, C. 2004, 'Migrants and employment: Challenging the success story', *Journal of Sociology*, vol. 40, no. 3, pp. 237–59.

Houston, S. (2007). 'Health Equity in Aboriginal Health Promotion: introductory remarks', in *Aboriginal Health Promotion Forum*, *1 May 2007,* Australian Health Promotion Association, Adelaide Convention Centre.

Howden-Chapmen P, Crane J, Matheson A, Viggers H, Cunningham M & Blakely T 2007. 'Effective Retrofitting houses with insulation to reduce health inequalities', *Social Science and Medicine,* vol. 61, pp. 2600-10.

Howe, B. 2007, *Weighing Up Australian Values,* University of NSW Press Ltd, Sydney.

Internal feedback (2005). Emails from researchers during VicHealth's consultation on the Health Inequalities Position Statement identified frustration at lack of funding opportunities available for evaluation.

Irwin, L. G., Siddiqi, A. & Hertzman, C. 2007, 'Early Child Development: A Powerful Equalizer, Final Report', World Health Organisation.
Kavanagh, A., Thornton, L., Tattam, A., Thomas, L., Jolley, D. & Turrell, G. 2007, 'Place does matter for your health: A report of the Victorian lifestyle and Neighbourhood Environment Study', University of Melbourne.

Kavanagh, A. M., Goller, J. L., King, T., Jolley, D., Crawford, D. & Turrell, G. 2005, 'Urban area disadvantage and physical activity: a multilevel study in Melbourne, Australia', *J Epidemiol Community Health*, vol. 59, no. 11, pp. 934–40.

Kawachi, I. & Subramanian, S. V. 2007, 'Neighbourhood influences on health', *J Epidemiol Community Health*, vol. 61, no. 1, pp. 3–4.

Keleher, H. & Armstrong, R. 2005, '*Evidence-based Mental Health Promotion Resource'*, Department of Human Services
Victorian Health Promotion Foundation, Melbourne.

Kisely, S., Smith, M., Lawrence, D., Cox, M., Campbell, L. A. & Maaten, S. 2007, 'Inequitable access for mentally ill patients to some medically necessary procedures', *CMAJ*, vol. 176, no. 6, pp. 779–84.

Klein, H. 2004, 'Health inequality, social exclusion and neighbourhood renerwal: Can place-based renewal improve the health of disadvantaged communities?', *Australian Journal of Primary Health*, vol. 10, no. 3, pp. 110–9.

Korpi, W. & Palme, J. 1998, 'The paradox of redistribution and strategies of equality: welfare state institutions, inequality and poverty in western countries', *American Social Review*, vol. 63, pp. 661–87.

LaMontagne, A., Shaw, A., Ostry, A., Louie, A. & Keegel, T. 2006, '*Workplace Stress in Victoria – Developing a Systems Approach: Full Report*', Victorian Health Promotion Foundation, Melbourne.

Lupton, R. 2003, *'Neighbourhood Effects': Can we measure them and does it matter?'* Centre for Analysis of Social Exclusion
London School of Economics, London.

Lynch, J., Harper, S. & Davey Smith, G. 2007, 'Relevant Risk, Revisiting Rose and Revolution: Reflections on 25 years of epidemiological evidence on the causes of population levels and social inequalities in CHD', in *VicHealth Seminar,* Melbourne.

Macintyre, S., Ellaway, A. & Cummins, S. 2002, 'Place effects on health: how can we conceptualise, operationalise and measure them?' *Soc Sci Med,* vol. 55, no. 1, pp. 125–39.

McCracken, K. 2001, 'Into a SEIFA SES cul-de-sac?' *Aust N Z J Public Health,* vol. 25, no. 4, pp. 305-6.

Ministerial Advisory Committee for Victorian Communities 2006, *'Strong Communities: Ways Forward Executive Summary'*, Melbourne.

Ministry of Health & University of Otago 2007, *'Decades of Disparity IV: Ethnic and socioeconomic inequalities in mortality, New Zealand 1987-1999'*, Ministry of Health, Wellington.

Moore, D.T. 2006a, 'Early Childhood and Long term Development: the Importance of the Early Years', ed ARACY, Australian Research Alliance for Children and Youth.

Moore, D.T. 2006b, 'Early Childhood and Long Term Development: The Importance of the Early Years', in *Evidence into Action Topical Papers,* ed ARACY, Centre for Community Child Health, Murdoch Children's Research Centre, Royal Children's Hospital, Melbourne.

Mowbray, M. 2004, 'Postcodes and destiny: The selective application of research on social capital', *Just Policy,* no. 34, pp. 43–7.

Navarro, V. (ed) 2007, *Neoliberalism, Globalization, and Inequalities: Consequences for Health and Quality of Life,* Baywood Publishing Company, New York.

Newman, L., Baum, F. & Harris, E. 2006, 'Federal, State and Territory government responses to health inequities and the social determinants of health in Australia', *Health Promot J Austr,* vol. 17, no. 3, pp. 217–25.

Nicholson, J., Carroll, J.-A., Brodie, A., Waters, E. & Vimpani, G. 2004, *'Child and Youth Health Inequalities in Australia: The status of Australian research',* Queensland University of Technology.

Oreopoulos Philip 2005, *'Neighbourhood Effects in Canada: A Critique'*, University of Toronto, Department of Economics National Bureau of Economic Research Statistics Canada, Family and Labour Studies Division.

Pappas, G. 2006, 'Geographic data on health inequities: understanding policy implications', *PLoS Med*, vol. 3, no. 9, p. e357.

Paradies, Y. 2007, 'Racism', in *Social Determinants of Indigenous Health*, eds B. Carson, T. Dunbar, R. Chenhall and R. Bailie, Allen & Unwin, Crows Nest.

Parkes, A. & Kearns, A. 2006, 'The multi-dimensional neighbourhood and health: a cross-sectional analysis of the Scottish Household Survey, 2001', *Health Place,* vol. 12, no. 1, pp. 1–18.

Pearce, J., Witten, K., Hiscock, R. & Blakely, T. 2007, 'Are socially disadvantaged neighbourhoods deprived of health-related community resources?' *Int J Epidemiol*, vol. 36, no. 2, pp. 348–55.

Petticrew, M. 2007, ''More research needed': plugging gaps in the evidence base on health inequalities', *Eur J Public Health,* vol. 17, no. 5, pp. 411–3.

Prus, S. G. 2007, 'Age, SES, and health: a population level analysis of health inequalities over the lifecourse', *Sociol Health Illn*, vol. 29, no. 2, pp. 275–96.

Pulver, L. J., Harris, E. & Waldon, J. 2007, *'An overview of the existing global knowledge on the social determinants of Indigenous health and wellbeing in Australia and New Zealand'*, Public Health Association of New Zealand.

Randolph, B. & Holloway, D. 2007, 'Where do low-income private renters live?' in *AHURI Research & Policy Bulletin,* Australian Housing and Urban Research Institute, Melbourne.

Raphael, D. 2006a, 'Social determinants of health: present status, unanswered questions, and future directions', *Int J Health Serv,* vol. 36, no. 4, pp. 651–77.

Raphael, D. 2006b, 'The social determinants of health: what are the three key roles for health promotion?' *Health Promot J Austr,* vol. 17, no. 3, pp. 167–70.

Raphael, D. & Bryant, T. 2006, 'The state's role in promoting population health: public health concerns in Canada, USA, UK, and Sweden', *Health Policy*, vol. 78, no. 1, pp. 39–55.

Robinson, V., Tugwell, P., Petticrew, M., Kristjansson, E., Waters, E., Cuervo, L. & Volmink, J. 2005, 'What works at enhancing health equity? Cochrane and Campbell Evidence Base', in *Global Forum Update on Research for Health,* Global Forum for Health Research, pp. 64–7.

Rose, G. 2001, 'Sick individuals and sick populations. 1985', *Bull World Health Organ,* vol. 79, no. 10, pp. 990–6.

Stanley, J., Ng, C. W. & Mestan, K. 2007, *'Social exclusion in Boroondara, Stage Two: identifying the issues for children who experience social exclusion in Boroondara'*, Brotherhood of St Laurence, Fitzroy.

Thomson, H., Atkinson, R., Petticrew, M. & Kearns, A. 2006, 'Do urban regeneration programmes improve public health and reduce health inequalities? A synthesis of the evidence from UK policy and practice (1980–2004)', *Journal of Epidemiology and Community health,* vol. 60, pp. 108-15.

Thomson, H., Hoskins, R., Petticrew, M., Ogilvie, D., Craig, N., Quinn, T. & Lindsay, G. 2004, 'Evaluating the health effects of social interventions', BMJ, vol. 328, no. 7434, pp. 282–5.

Thomson, H., Morrison, D. & Petticrew, M. 2007, 'The health impacts of housing-led regeneration: a prospective controlled study', *J Epidemiol Community Health,* vol. 61, no. 3, pp. 211–14.

Thomson, H. & Petticrew, M. 2007, 'Housing and health', *BMJ,* vol. 334, no. 7591, pp. 434–5.

Tobias, M. & Searle, P. 2006, 'Does geography explain ethnic inequalities in health in New Zealand?' *Aust NZ J Public Health,* vol. 30, no. 5, pp. 457–60.

Tobias, M. & Yeh, L. C. (2007). 'How much does health care contribute to health inequality in New Zealand?' *Aust N Z J Public Health,* vol. 31, no. 3, pp. 207-10.

Turrell, G., Kavanagh, A., Draper, G. & Subramanian, S. V. 2007a, 'Do places affect the probability of death in Australia? A multilevel study of area-level disadvantage, individual-level socioeconomic position and all-cause mortality, 1998-2000', *J Epidemiol Community Health,* vol. 61, no. 1, pp. 13–9.

Turrell, G., Lynch, J. W., Leite, C., Raghunathan, T. & Kaplan, G. A. 2007b, 'Socioeconomic disadvantage in childhood and across the life course and all-cause mortality and physical function in adulthood: evidence from the Alameda County Study', *J Epidemiol Community Health*, vol. 61, no. 8, pp. 723–30.

Turrell, G., Stanley, L., Looper, M. d. & Oldenburg, B. 2006, *Health Inequalities in Australia: Morbidity, health behaviours, risk factors and service use,* Australian Institute of Health and Welfare and Queensland University of Technology, Brisbane.

VicHealth 2007, *'More than tolerance: Embracing diversity for health: Discrimination affecting migrant and refugee communities in Victoria, its health consequences, community attitudes and solutions - A summary report'*, Victorian Health Promotion Foundation, Melbourne.

Victorian Health Promotion Foundation 2005, *'VicHealth Position Statement on Health Inequalities'*, VicHealth, Melbourne.

Wagstaff, A., Paci, P. & Joshi, H. 2001, *Inequalities in Health: Who You Are? Where You Live? Or Who Your Parents Were?*, SSRN.

Wakefield, M. 2007, 'Smoking prevalence and consumption in Victoria: key findings from the 1998–2006 population surveys ', in T*obacco Control: Where to from here? A collaborative forum for DHS, VicHealth, Quit and VicHealth Centre for Tobacco Control staff,* VicHealth.

Warr, D. J. 2005, 'Social networks in a "discredited" neighbourhood, *Journal of Sociology,* vol. 41, no. 3, pp. 285–308.

Whitehead, M. 2007, 'A typology of actions to tackle social inequalities in health', *J Epidemiol Community Health*, vol. 61, no. 6, pp. 473–8.

Whitehead, M. 1998, 'Diffusion of ideas on social inequalities in health: a European perspective', *Milbank Q*, vol. 76, no. 3, pp. 469–92, 306.

Whitehead, M. & Dahlgren, G. 2006, '*Levelling Up (part 1): a discussion paper on concepts and principles for tackling social inequities in health'*, WHO Europe, Copenhagen.

Wilkinson, R. & Marmot, M. eds 2003, 'Social determinants of health: the solid facts', World Health Organisation.

Wiseman, J. 2006, 'Local Heroes: Learning from Recent Community Strengthening Initiatives in Victoria', *Australian Journal of Public Administration,* vol. 65, no. 2, pp. 95–107.

Ziller, A. 2006, 'Relative equality: practical implications for land use planners', in Address to the *ACT Branch of tyhe Planning Institute of Australia,* Australia Street Company.

Ziller, A. 2004, 'The Community is Not a Place and Why It Matters - Case Study: Green Square', *Urban Policy and Research,* vol. 22, no. 4, pp. 465-79.

Victorian Health Promotion Foundation
PO Box 154
Carlton South Victoria 3053 Australia
Phone: +61 3 9667 1333
Fax: +61 3 9667 1375
Email: vichealth@vichealth.vic.gov.au

April 2008

www.vichealth.vic.gov.au