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VICHEALTH LETTER

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Editorial

Inequalities in Health

Why should we be interested in inequalities in health?

Ask Australians and you will probably find that most agree we all want to enjoy good health and that, as far as it is possible, it should be available equally to all.

Studying inequalities in health teaches us a great deal about what determines good and bad health. Sir Michael Marmot and Richard Wilkinson, who are at the forefront of research into health inequalities, tell us that childhood environment, the work environment, unemployment, patterns of social relationships, social exclusion, food, addictive behaviour and transport are all major determinants of our health.[1] It is certainly more than just our genetic make-up, our individual behaviours or our access to medical care which determines how healthy we are.

The work of Harvard-based researchers Ichiro Kawachi, Bruce Kennedy and Lisa Berkman, and expatriate Australian John Lynch indicates that countries and states that have less income inequality also seem to have lower mortality rates. Similarly, countries that prioritise redistribution through fiscal and social policies have lower health inequalities and better overall population health than those that don't. By 'sharing our wealth' (in its broadest sense), it seems we can also 'share our health'.

As we show in this *VicHealth Letter*, health inequalities exist in Australia. Dr Theo Vos' work (p. 15) shows that men in Victoria live five and a half years less than women. If you live in the City of Manningham you can expect to live seven years longer than someone living in the City of Yarra, only a relatively short bus trip away.

These inequalities exist across a range of health status indicators—mortality (all-cause and specific), morbidity and life expectancy. While some of these inequalities can be explained by genetic or biological factors, many are not. Inequalities also exist in immediate determinants of health, such as our health knowledge, attitudes and behaviours and access to health and preventative services.

If we accept that health is a basic right for all of us, then these inequalities in health are unacceptable. But are those involved in health promotion inadvertently increasing the gaps between the health-haves and the health-have-nots? Gavin Turrell (p. 12) suggests that in some cases we are.

So, should we do nothing if we risk improving the overall health of Victorians at the expense of increasing the relative difference between the health-haves and the health-have-nots, as is occasionally suggested? No. Turrell suggests we need to simultaneously improve the overall level of population health while striving to narrow the gap between those with the lowest health status and those with the highest.

Inequalities in health can be a function of many things. The relationships are complex and the range of possible interventions is wide. The United Kingdom Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson, stated that 'without a shift in resources to the less well off, both in and out of work, little will be accomplished in terms of a reduction in health inequalities'. Others suggest that 'inequalities in health can only be effectively tackled by policies that reduce poverty and income inequality'.[2] So does this mean that health promoters should stop until these bigger issues are addressed? To the contrary—we need to debate and research all the reasons why health may differ between different groups and trial possible solutions. This issue of *VicHealth Letter* is one vehicle for continuing this discussion.

Dr Rob Moodie
Chief Executive Officer

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Overview

Inequalities in Health

VicHealth is committed to improving population health. Narrowing the inequalities in health that exist between sections of the community while making a demonstrable contribution to trend for overall population health is one of VicHealth's goals.

Differences in health status

There are clear differences in health between different groups of people in Australia, including differences in rates and patterns of death and disease, life expectancy and self-perceived health.

Groups of Australians who have poorer health include people from lower socioeconomic groups (e.g. low income blue-collar workers) and Indigenous Australians. People who live in certain areas also have poorer health, including people who live in rural areas of Australia and people who live in low income areas.

Many of these differences are preventable as they are not due to genetic or biological factors. Instead, they are related to social inequalities. Evidence suggests 'health inequalities are the outcomes of causal chains which run back into and from the basic structures of society'[1]. Inequalities in health status result from interactions between many so-called 'layers of influence'. Macro socioeconomic, cultural and environmental conditions influence living and working conditions, which affect social and community networks, which influence individual lifestyles, which in turn influence health.[1,2] For example, Sally MacIntyre's work (article on page 8) shows us that differences in living and working conditions (such as the availability of exercise facilities and healthy food) may be linked to differences in levels of trust and community interaction as well as patterns of sedentariness or a poor diet. These in turn may be linked to differences in health and life expectancy between groups.

Differences in living and working conditions, social and community influences and individual lifestyle factors are preventable or reducible, as are the differences in health associated with them.

Definition — Inequalities in Health

Health inequalities are potentially preventable differences in the health of one group of people when compared to another group.

Influences on health

Socioeconomic status

Just as socioeconomic status determines our 'life chances', it also determines our 'health chances'.

Socioeconomic status is a major predictor of health outcomes across all societies. Socioeconomic differences in health exist for males and females at all stages of the lifespan. Low socioeconomic status is associated with higher rates of disease in most systems of the body and is related to higher rates of death for all leading causes of death.[3–7] In Victoria, heart disease, emphysema, diabetes, asthma, sudden infant death syndrome, road traffic accidents and homicide are the important causes of deaths where different rates of incidence are associated with large socioeconomic differences.[8]

While people in lower socioeconomic groups have the worst health status, there is evidence of a gradient effect. Health improves as socioeconomic status rises.[9–11]

Examples of Health Inequalities

Indigenous/Non-Indigenous Australians

- Victorian Aboriginal men and women have a life expectancy which is 8–18 years lower than the State average.[12]

Local Government Areas

- Life expectancy in 1996–99 for females in Nillumbik was 83.98 years. In Melton, the average life expectancy for females was 78.79 years.
- Life expectancy in 1996–99 for males in Manningham was 79.26 years. In Maribyrnong, the average life expectancy for males was 73.97 years.

Males and Females

- Average life expectancy of males was 5.45 less than females in Victoria in 1996–99. Average life expectancy for females was 81.99 years. Average for males was 76.9 years.[13]

Unequal access to material factors necessary for health such as good housing, adequate income, healthy food and health services can explain much of this differential in health. Social and material inequalities may also have an impact on psychosocial mechanisms, such as individual stress, low self-esteem and social mistrust and isolation. These may also contribute to poor health in disadvantaged groups.[14,15]

Life course

Everyone in the community is exposed to a series of environmental, social and psychosocial factors which accumulate over time to determine our health status. Some of these exposures are health enhancing (such as the availability of healthy food) and some are health damaging (such as exposure to passive smoking); the balance of these cumulative exposures over time influences our health. Different groups experience these exposures differently. For example, Indigenous people and people from minority ethnic groups experience interpersonal racism as a health damaging exposure; people from the majority ethnic group do not experience this or do not experience it in the same way. This cumulative differential exposure to health damaging and health enhancing factors over a lifetime contributes to differences in health status between groups.

Everyone in society faces transitional phases or periods in life that can play an important role in our health and welfare. These include early childhood, the moves from primary to secondary education and from education to workplace, leaving home, starting a family and retirement. These periods are times which are crucial to our life chances and health chances. Childhood is a particularly important time because of the influence of early life on developing behaviours and subsequent health and development. Some suggest, therefore, that interventions that relate to present and future parents, especially mothers and children, have the best chance of reducing future inequalities in health.[1,2,16]

Geographical area

As well as health inequalities relating to different population subgroups, spatial health inequalities exist across different geographical areas. Mortality in the most disadvantaged local government areas (LGAs) in Victoria is 30% higher for men and 19% higher for women than in the least disadvantaged LGAs. The work undertaken by Dr Theo Vos on the Victorian Burden of Disease estimates for LGAs in Victoria (see page 15) reveals that male life expectancy in the municipality of Yarra is 71.7 years compared with 78.5 years in the City of Manningham, for example. These municipalities are only approximately 10Km apart but have a difference in life expectancy of nearly seven years. Inequalities in health also exist between rural and urban Victorians.

What is the relationship between differences in the health of subgroups of the population and groups of people who live in different areas? Spatial inequalities are accounted for mostly by differences in the circumstances and characteristics of the individuals living in the area (for example, a greater proportion of people with low income, lower educational status and other characteristics which place them at risk of poor health live in the municipality of Yarra than in Manningham).[13]

Up and Down: Addressing the issue is complex.

However, some of the differences in health between these areas also relate to the impacts that places and communities have on the people that live in them. These impacts may affect everyone who lives in that place or community, not only those individuals who, because of their socioeconomic status, are at increased risk of poor health. They suggest that environment has an important role and exerts area-level influences on health.

Spatial health inequalities are very significant as they suggest that social inequalities impact on everyone's health, not only those groups who are disadvantaged—health inequalities are everyone's business.

Addressing health inequalities: strategic challenges for health promotion

Macro social and economic policy approaches

Social, cultural, economic and environmental factors influence individual health through direct impacts on individuals and, potentially, through area-level influences.[15] Macro-level policy approaches which address disadvantage may be effective in reducing health inequalities. Nordic countries with redistributive fiscal and social policies, such as progressive taxation and social security benefits pegged to average incomes, have lower income inequality, lower health inequalities and better overall population health status than countries such as Australia, the United States and the United Kingdom.

A challenge for health promotion advocates is to investigate how health inequalities might relate to social and economic forces and to explore and suggest macro social policy responses to reduce them.

Information and behavioural approaches

Conventional approaches to health promotion have sought to influence the behaviour of individuals through population-wide promotional campaigns. There is some evidence that in some cases this type of approach may increase, rather than decrease, health inequalities. For example, although the rate of smoking has been reduced through health promotion interventions over the last 20 years, the rate of smoking in higher socioeconomic groups has decreased more rapidly than in lower socioeconomic groups. So, even though smoking rates across the population have declined, the gap between socioeconomic groups has increased.

In Victoria Quit has recognised this and targets groups with a higher smoking prevalence in a number of ways. Communications messages designed to appeal to smokers from a lower socio-economic demographic and media placements taking into account audience profiles across print, radio and television outlets are just two examples.

Quit has also established specific programs to target vulnerable groups such as ethnic communities, aboriginal smokers, and young smokers. Staff members have been allocated to focus on addressing smoking cessation in each of these population groups. These staff work directly with relevant community organisations, provide training, develop resources specifically for these population groups, and incorporate specific population groups into campaign planning and execution.

Health promotion must therefore be effectively tailored to reach special population groups and involve more effective population-wide strategies, such as policy and environmental approaches,[17-19] to ensure that population health can continue to improve while disparities narrow.

Working with people and places

In order to produce population-wide health benefits and reduce health inequalities, health promotion activities must engage and work with both people and places. This includes moving beyond solely targeting individual and personal behaviours to addressing social, economic and environmental issues. It also requires greater engagement with a range of sectors, including infrastructure, housing, education and employment. This is aligned with VicHealth's strategic objective to work in partnership with other sectors and share responsibility for health.

Interrupting the cycle of poverty and ill-health

The relationship between poor health and social disadvantage may to some extent be cyclical. Although evidence suggests that it is social status which determines health rather than the reverse, poor health may also result in downward social mobility. Low income and poverty may result in poor health, which may in turn result in further loss of income and increasing poverty. Inequalities in health between different groups may therefore further compound or increase the social inequalities between them.

Building an evidence base

There is a large theory base to explain the existence and causes of health inequalities but little good evidence on the effectiveness of interventions to reduce them.[19]

Health inequalities cannot be simply addressed, as the relationship with social inequalities is very complex. Social influences on health and the potentially cumulative effects of a variety of factors mean that much further work is required.

Studies measuring social mobility, socioeconomic status and health over time are needed to expand our understanding of the complex relationship between social disadvantage and poor health.[3,9,20]

This is the challenge that VicHealth, along with other organisations in government and non-government sectors, are taking up.

Underpinning VicHealth's Approach to Inequalities

- Health is a fundamental human right.
- The aim of health promotion should be to reduce or eliminate health differences that result from factors that are considered avoidable and unfair.
- VicHealth adopts the WHO goal for health equity which is concerned with creating equal opportunities for health and bringing health differentials down to the lowest level possible.
- Societies that strive to enable all individuals to participate fully in social, economic and cultural life are more likely to have healthy citizens than societies which allow individuals to be excluded, marginalised and deprived.
- Initiatives to reduce health inequalities need to address different 'layers of influence', from strengthening individuals and communities to improving access to essential services and facilities and encouraging macroeconomic and policy change that improves health.

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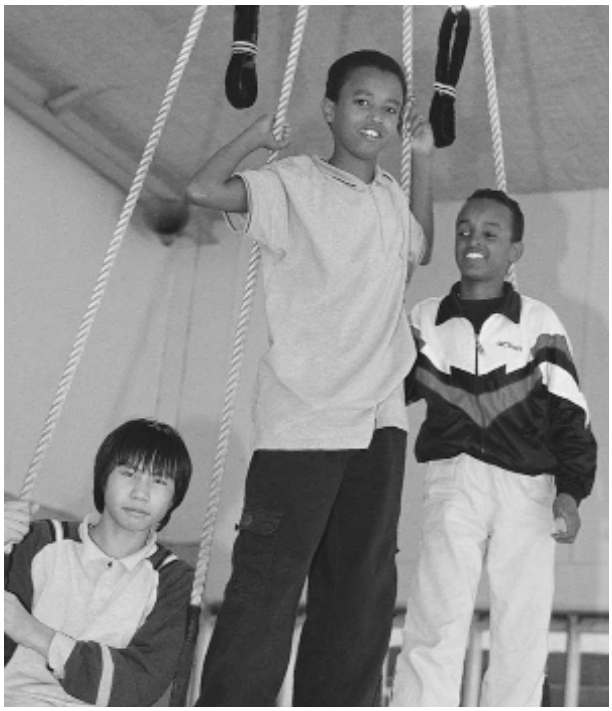
New Research Networks on Health Inequalities



Children and Youth. A focus for one of the networks.

A Commonwealth Initiative (HIRC) has been developed to assist researchers to engage in work which will improve our understanding of health inequalities

Three national networks are being established as a core part of the Health Inequalities Research Collaboration (HIRC). HIRC, an initiative of the Commonwealth Government, is designed to assist research workers to apply their energies to improving our understanding of health inequalities, what causes them and how they may be ameliorated. This support includes clarifying research priorities, supporting networking by researchers advocating for more funding support for such research. HIRC is especially keen to foster research which tests interventions on the basis of sound theory.

Functioning as an institute without walls, HIRC is building the three networks in subject areas which the evidence suggests are instrumental to improving health and reducing health inequalities.

The HIRC network subject areas and their coordinating teams are:

Children, Youth and Families
Coordinated by:

Dr Jan Nicholson, School of Public Health Research, Queensland University of Technology

Dr Elizabeth Waters, Murdoch Children's Research Institute, Melbourne

Professor Graham Vimpani, University of Newcastle

Network contact: Julie-Anne Carroll,
Ph: (07) 3864 5611; email: jm.carroll@qut.edu.au

Primary Health Care
Coordinated by:

Ms Elizabeth Harris, Centre for Health Equity, Research, Training and Evaluation, NSW

Dr John Furler, Department of General Practice, University of Melbourne

Network contact: Julie McDonald,
Ph: (02) 4236 0225; email: maclyle@1earth.net

Sustainable Communities
Coordinated by:

Dr Pierre Horwitz, Edith Cowan University

Network contact: Meredith Green, Ph: (08) 9400 5677;
email: meredith.green@ecu.edu.au

Each network will be responsible for:

- Establishing and maintaining a comprehensive and viable research network and addressing rural health and the health of Indigenous Australians in their work;
- Providing expert advice on priority research topics, questions and related matters – this includes advice on the evidence for effective interventions;
- Facilitating communication and collaboration between network members and other individuals and groups; and
- Undertaking activities to build capacity in research concerning health inequalities as it applies to the subject areas.

Researchers, policy developers, practitioners and others interested in the subject areas covered by the three HIRC networks are welcome to contact these networks.

For general information about HIRC, contact Helen Catchatoor, HIRC Secretariat, email: helen.catchatoor@health.gov.au or check our website at http://www.hirc.health.gov.au.

Place and Health in the United Kingdom

What role do social and physical contexts play in influencing health? Sally MacIntyre, MRC Social and Public Health Sciences Unit, University of Glasgow, and a world leader in research relating to inequalities in health explains in this article for VicHealth.

Since 1987, we , at the University of Glasgow, have been studying the social and spatial patterning of health in Scotland. Initially our empirical work focused on communities within Glasgow City but more recently our work has expanded to cover a range of types of places in the UK. This article outlines some of our evolving thinking about the role of social and physical contexts in influencing health and describes some of our studies and findings.

Firstly, some macro context: Scotland has among the highest age–sex standardised mortality rates in the industrialised world and is often described as 'the sick man of Europe'. Even controlling for occupational social class, death rates are higher than in most regions in England.

Glasgow flourished in the 19th century as a trading port (being a major tobacco importer and processor) and a centre of heavy manufacturing industry (building ships and railway engines that were exported to far-flung corners of the British Empire). The Scottish and Glaswegian economies started declining after the Second World War with the demise of the coal, tobacco and manufacturing industries. Scotland is now a post-industrial society dependent on tourism, agriculture, oil and the service sector. Scotland now, as in previous centuries, contains wealthy, salubrious areas as well as those characterised by poverty and poor resources. The West of Scotland, where Glasgow is located, has always contained pockets of extreme social and material deprivation. The wide range of types of people and places in Scotland offers good opportunities for studying the social and physical patterning of health.

We started our research with a framework that suggested that the following features of the local environment might be health promoting or health damaging:

- the physical features of the environment shared by all residents in a locality;
- the availability of healthy environments at home, work and play;
- the services provided to support people in their daily lives;
- the sociocultural features of a locality; and
- the reputation of an area.[1]

We conceptualised these as 'opportunity structures', that is, features of the physical and social environment which may promote or damage health, either directly or indirectly, through the possibilities they provide for people to live healthy lives. (An example of a direct effect would be polluted air compromising the health of residents; an example of an indirect effect would be the local availability of affordable and nutritious food since not all individuals are totally dependent on local food supplies).

In our work in Glasgow we used two socially contrasting localities in which to measure a number of these features directly. For example, we examined the number of dwellings with water supplies that exceeded the European Community's guidelines for lead content[1] and the distribution of food retail outlets and the pricing of different types of food.[1,2] We have been collecting data both about the areas (either directly, through collecting primary or secondary data about features of the environment or indirectly through the eyes of the residents) and about the residents and their everyday lives and health.

Our main finding has been that the 'inverse care law' does not apply only to health services: most resources which people need to lead healthy lives are less available, or of poorer quality, in areas inhabited by people whose personal or household resources are also poorer. We call this phenomenon 'deprivation amplification'. For example, facilities for physical recreation may be fewest in areas where public and private transport is scarce, people are least likely to have their own facilities and where the local environment is not conducive to walking, cycling or jogging.[3–6] This finding may not be surprising to those who wander around different areas in big cities but it does not feature much in many health promotion or public health policies.

The most recent Scottish White Paper on public health has as its main aim 'a coordinated three-level approach to better health with an overarching focus on tackling health inequalities'. These three levels are life circumstances (such as unemployment, poverty, poor housing), lifestyles (reducing smoking, alcohol misuse, etc.) and health outcomes (corony heart disease, cancer, accidents, etc.).

Although the White Paper sets targets for lifestyles and health outcomes, it does not set any targets for life circumstances.[7] Given time lags in the production of inequalities in health outcomes, particularly for the major killers such as cancer, stroke and coronary heart disease, it would seem feasible to set targets for a reduction in disparities between areas in local opportunity structures even though this may be difficult. One could, for example, monitor area variations in food retail provision, employment opportunities, unfit or substandard housing, recreation facilities, public transport, community resources, childcare facilities and education, health and welfare services. One could then set targets for ensuring that every community over a certain size has access to basic facilities such as a grocery store, bus or train services, safe play areas for children, a community hall or meeting place, child care facilities, a Post Office, banks, etc.

We have taken this idea forward in our current work. We have suggested that a starting place for conceptualising, measuring and monitoring area influences on health is to consider what humans need in order to live a healthy life, given their particular socioeconomic and sociocultural context. Our list of such needs starts roughly in the order of Maslow's hierarchy of human needs.[8] They appear below:

Needs for Health

- **Air**: unpolluted air
- **Water**: clean water for drinking and cooking
- **Food**: adequate supplies of nutritious and non-poisonous food
- **Shelter**: protection from wind, cold and rain
- **Security**: protection from threats to person or property
- **Hygiene**: protection from infectious or contagious disease and from toxins and pollutants
- **Education**: socialisation in the skills and information needed in a given society
- **Healing**: care and treatment for the sick and infirm
- **Housekeeping**: resources for food storage and preparation, cleaning (of people, clothes and homes) and waste disposal
- **Work**: gainful labour
- **Means of exchange**: money, credit or other forms of trading power
- **Information**: access to prevailing media of information and communication (books, newspapers, postal and telecommunications services, etc.)
- **Transport**: private and public transport, roads, railways
- **Personal relationships**: family life, intimate relationships, acquaintance and friendship networks
- **Religious**, spiritual or ritual practices
- **Involvement in group activities**: participation in political, social or economic activities
- **Play**: social, cultural and physical recreation

Education: Access and levels reached vary

Physical environment: Contributes to health status in area

Social environment: Improves sense of belonging and wellbeing.

Childcare facilities: Important factor for providing opportunities.

How these needs are met depends on the sociocultural context and the state of technological development and wealth, as well as how these are distributed. (For example, bicycles may be an extremely important means of transport in China and parts of Africa, whereas cars, airports and trains may be more important in other countries.) It seems useful to ask, within a given society, how the resources available to meet these needs are distributed spatially and whether this distribution is related to the distribution of health. This means developing measures, appropriate for the particular society and historical period, of the ways in which these human needs are met in particular places.[9]

Health Promoting or Health Damaging

- the physical features of the environment shared by all residents in a locality;
- the availability of healthy environments at home, work and play;
- the services provided to support people in their daily lives;
- the sociocultural features of a locality; and
- the reputation of an area.[1]

We are using this approach to studying variations in health within neighbourhoods in England and Scotland. We have taken each of the above domains and tried to find multiple and accessible indicators of them. (For example, for physical recreation, we are mapping private and public sports facilities, children's playgrounds, parks/green spaces and local government expenditure per capita on sports facilities.) We are doing this for a sub-sample of the postcode sectors which were included in the most recent large-scale health monitoring surveys in the UK (the Health Survey for England 1999 and the Scottish Health Survey 1998). Data on personal circumstances, mental and physical health, and health behaviours and risks were collected in these surveys on random samples of the population. More recently, colleagues at University College London have collected data on social capital and social cohesion by postal survey, using the same areas but different samples of the population. Thus, we will eventually have three sets of data on each of 841 neighbourhoods: health and personal circumstances, reported levels of social capital and cohesion and levels of material and social infrastructure. The (ambitious!) aim is to model relationships between these three in order to examine the influence on health and health related behaviours of local opportunity structures and social capital.

Definition — Inverse Care Law

Resources which people need to live healthy lives are less available or of poorer quality in areas inhabited by people whose personal or household resources are also poorer.

Although Scotland differs in many regards from Australia (geographically, socially and economically), I believe the principles behind our approach are equally applicable in Australia. Given *VicHealth Letter's* recent focus on physical activity, I have chosen to illustrate our work with examples from physical activity, but, again, I believe the same research and policy principles can be applied across all the health related domains of human environments and activities.

Acknowledgement

I would like to acknowledge the collaboration of my colleagues Anne Ellaway (formerly Sooman) and Steven Cummins.

Sally Macintyre can be contacted at the University of Glasgow at Sally@msoc.mrc.gla.ac.uk.

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Takeaway: Dr Reidpath's study focused on the major fast food franchises through 267 postcode areas in Melbourne.

Whatever's Close

Deakin University's Dr Daniel Reidpath has found that Melburnians who live in areas with the lowest individual median weekly incomes have two and a half times the exposure to five major fast food franchise outlets than those living in areas with the highest individual median weekly incomes.

The study, which looked at 267 postcode areas (excluding Melbourne 3000 and Airport), provides an interesting illustration of how physical environments may differ in areas of differing socioeconomic status. Reidpath admits, however, that his paper is about raising questions rather than making definitive statements. He believes it likely that decisions by major fast food outlets to build in these areas are influenced mainly by the economics of more affordable and available land. Reidpath says the one definitive thing you can say about his results is that the poor are more exposed than the rich to major fast food franchise outlets. A causal relationship should not be presumed between the positioning of fast food outlets and the increasing prevalence of obesity in industrialised countries, a trend particularly apparent among the poor. However, it can be presented as one possible explanation and is worthy of further investigation.

Number of fast-food outlets, population, and population per fast-food outlet by the median weekly income category from the lowest income group (SES 4) through to the highest (SES 1)

Income category	Postal districts	Fast food outlets*	Population	Population per fast food outlet
SES 4	12	29	163 589	5 641
SES 3	71	109	941 527	8 638
SES 2	156	171	174 442	10 196
SES 1	28	22	291 093	14 256
Total	**267**	**331**	**3 162 198**	**9 553**

**Fast food outlets: Hungry Jacks, Red Rooster, McDonald's, Kentucky Fried Chicken, Pizza Hut*

Reidpath's short report—'An ecological study of the relationship between social and environmental determinants of obesity'—will be published in Health and Place in 2002. He completed the report with Cate Burns, Jon Garrard, Mary Mahone and Mardie Townsend.

Socioeconomic Health Inequalities

Gavin Turrell, School of Public Health, Queensland University of Technology, asks what role is there for health promotion in addressing socioeconomic health inequalities.

During the last few decades, Australia has witnessed marked improvements in the health of its population. Since the late 1960s, for example, mortality rates from heart attack (ischaemic heart disease) and stroke (cerebrovascular disease) have declined, and since the early 1990s deaths from lung, colorectal and breast cancer have also begun to fall.[1,2] Not all groups in the population, however, have shared equally in these health gains. Table 1 exemplifies these points. Despite substantial overall reductions in age-standardised death rates between 1985–87 and 1995–97, the size of the mortality gap between the most and least socioeconomically disadvantaged areas remained large. This is evident if you measure the increasing ratios between SES groups for mortality types.[3]

Many of the conditions identified in table 1 have been the focus of sustained health promotion efforts via, for example, improvements in diet and physical activity and anti-smoking campaigns. While these efforts have very likely contributed to improving everyone's health, there is increasing evidence that health promotion has been least effective among people from disadvantaged backgrounds[4] and that traditional approaches to promoting health have inadvertently widened health differences between socioeconomic groups.[5]

Any strategic approach to reducing socioeconomic health inequalities needs to have health promotion as one of its core components. Here we present three issues that health promoters should consider in terms of improving the health of socioeconomically disadvantaged groups while at the same time avoiding widening of the health gap.

First, health promotion efforts should be developed and implemented from a social-ecological perspective.[6] This perspective emphasises a direct relationship between people and their environments. More specifically, it takes the view that environments (such as the home, work, school or community) exert an influence on health separate from the characteristics of the individuals who inhabit them. To date, many health promotion efforts have been non-contextual and targeted at individual-level behaviour change, with limited consideration of the wider environmental constraints (such as poverty and geographic location) that can act to make behaviour change difficult. A social-ecological perspective suggests that health promotion needs to focus as much on the constraints and opportunities present in the context as on the individuals themselves.

Second, and related, a key to maximising the effectiveness of health promotion with disadvantaged groups is to develop and implement an approach that is tailored to their particular needs (with sensitivity, of course, to avoid stigma, labelling, stereotyping and other negative outcomes of being identified as a group with special needs). Often health promotion efforts are universal in nature and take a 'whole of population' approach. While this appears to have contributed to health improvements at the national level, this approach

Table 1: Age-standardised mortality rates (per 100 000), by area disadvantage: males and females 25–64 years, 1985–87, 1995–97a (a: source adopted from Turrell and Mathers 2001. b: High and low correspond to the least and most disadvantaged quintiles of the Index of Relative Socioeconomic disadvantage.)

	Males				Females			
	1985–8		1995–97		1985-87		1995-97	
	High SES	Low SES	High SES	Low SES	High SES	Low SES	High SES	Low SES
Mortality type								
All causes	338.4	568.5	250.4	410.8	189.9	285.5	150.1	218.4
Coronary heart disease	96.0	149.0	43.0	80.7	21.2	47.1	10.1	23.5
Stroke	13.1	27.5	7.7	16.0	10.8	18.4	6.0	10.2
Diabetes mellitus	4.2	7.3	4.3	9.0	1.9	5.8	1.9	6.7
Lung cancer	29.7	47.3	17.6	34.8	8.9	14.1	9.1	15.8
Respiratory system disease	13.7	31.7	8.0	20.0	8.8	18.2	6.1	16.2
Digestive system disease	10.3	31.4	8.8	19.3	5.4	12.2	3.9	8.7

Advantage: Childhood environments are vital

does not necessarily contribute to a reduction of health inequalities between socioeconomic groups. For this to happen, population-wide health promotion efforts need to be complemented by efforts that are designed with, and for, the socioeconomically disadvantaged.

Third, research is increasingly showing that a number of adult chronic diseases have their origins in early life, with propensity for adverse health in adulthood being greatest among those who experienced socioeconomic disadvantage in infancy and childhood.[7-8] Some of the more important findings of this work indicate that:

- health in adult life is the result of a complex interaction between socioeconomic and biological factors occurring at the beginning of life and then continuing throughout early life;
- biological and psychosocial development takes place within a social and economic context which structures life chances;
- there are 'critical periods' where humans are biologically and socially vulnerable; and
- the effect of social disadvantage and biological insults (e.g. being exposed to the effects of mothers smoking whilst in utero) accumulate longitudinally.

The implications of this evidence for health promotion are that efforts to reduce chronic disease in adulthood should encompass environmental contexts and individual behaviours in both early and later life, with a particular focus on mothers and children.

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Local Government: Resource

VicHealth is engaging with local government to address the issue of inequalities in health.

VicHealth, in partnership with the Department of Human Services (DHS), Municipal Association of Victoria (MAV) and local government councillors and senior managers, has developed a practical resource package which complements the DHS Environments for Health planning document. The package is designed to increase the level of understanding about the **social determinants of health** in the local government sector and how integrated planning processes can help create healthier communities. The long-term aim is to enable such issues to be incorporated into existing local government planning processes.

Activity on this project began in May 2000 when VicHealth ran a consultation forum in partnership with the MAV.

A Project Advisory Group consisting of representatives from the DHS, MAV, Victorian Local Governance Association, VicHealth, local councillors and senior managers was established to assist the consultants, PDF Management Services, develop the resource package for local councils. The development process began in June 2001. The overarching requirement of the package was that it should be practical enough to apply to existing local government planning processes.

Several challenges existed for the Group. First, 'social determinants of health' was a new concept to many within local government. This was underlined when feedback revealed that including social determinants in the title of the package would not engage the target audience (local government councillors and senior managers). The draft title was therefore amended to 'Local Government: Leading the Way to Healthier Communities'.

Second, practical issues needed to be taken into consideration. The size of the document, graphic explanation of concepts and use of consistent language were all items that were discussed during the development process.

The diversity of local circumstances and priorities and varying local government resources also meant 'one size would not fit all'. Thus, a key criterion for success was that the resource package would be flexible across a range of needs.

To assist development, the draft package was tested in seven councils. The pilot sites were the Shires of Corangamite, Towong, South Gippsland and Yarra Ranges and the Cities of Banyule, Brimbank and Greater Dandenong. An induction workshop for the chief executive officers, councillors and senior managers responsible for the Municipal Public Health Plan was held in Melbourne and an online discussion group has also been established.

The resource package is due to be completed in February 2002. The dissemination phase will begin in March. Consultation has shown that a multi-pronged approach to dissemination will be required to raise awareness and explain the potential benefits for the community.

Step one of the project is nearing completion. The next stage is about to begin.

For further information, please contact Kellie-Ann Jolly at VicHealth on (03) 9667 1358 or by email at kjolly@vichealth.vic.gov.au.

Different Spaces, Different Figures.

Life Expectancy at Birth (Ranking Order and Proportional Change), by Local Government Area, Victoria, 1992–1996 and 1996–1999 was developed by the Department of Human Services' Dr Theo Vos. It provides an excellent basis for debate about the nature of spatial inequalities.

Dr Theo Vos' figures on life expectancy at birth (LEB) by local government area (LGA) provides a solid starting point to explore the connection between where a person lives and their health status. (The figures for LEB are shown on p.15).

The data reveals that inequalities in life expectancy do exist within Victoria for both males and females according to where a person lives. It is still early days in terms of understanding what the raw information actually represents and what the range of issues are that cause the differences in life expectancy; however, it is an exciting basis for both researchers and policy makers to monitor trends and begin building policy to address the issue. Certainly, the Department of Human Services and organisations such as VicHealth are interested in applying policy to ensure the gap between areas does not widen and are working towards narrowing differences.

The material, published by Dr Theo Vos for the Department of Human Services, shows an overall trend of an improvement in life expectancy for both males and females in Victoria across the period. The gap between the LGAs with the highest and lowest male life expectancy reduced across the periods 1992–96 and 1996–99 while the gap in female life expectancy between areas increased.

The gap in life expectancy in the 1996-99 period between the LGA with the highest life expectancy and the LGA with the lowest life expectancy is significant—5.3 years for males and 5.2 years for females. This is a similar gap to the one that is present between the life expectancies of females and males—an issue that has been the subject of much debate. It is only recently, however, that people have begun trying to explain and interpret the disparity existing between geographical locations. Government policy is increasingly focusing on addressing this disparity.

The answers are not easily found. On one level, characteristics of a location's physical and social environment may improve the opportunity for individuals to access healthy lifestyles. As Sally McIntyre states in her article in this *VicHealth Letter*, this interpretation may not be surprising to many people 'who wander around different areas in big cities'.

Other interpretations suggest that there are a complex set of issues tied up with who lives where and the characteristics of the people that live in particular areas, and that those determinants of health less easily seen or stated play a large role in the variation in life expectancy between areas.

Figures at a Glance

- Overall trend of improvement in life expectancy for males and females across the period.
- Higher life expectancy is found in the inner eastern areas of Melbourne such as Manningham, Whitehorse and Monash for both males and females.
- Matching between male and female life expectancy is closer at the upper end of the spectrum.
- There are fewer areas where female life expectancy rates are worse than average than there are areas where the male rates are worse than average.
- Over the two time periods (1992–96 and 1996–99) there is quite distinct improvement for men in certain areas.
- The age profile of certain areas during the collection of data may impact upon the figures.

Two VicHealth projects

VicHealth has funded two research projects designed for the Victorian community to gain a better understanding of what role place plays in determining health. Dr Anne Kavanagh, a VicHealth senior research fellow, is involved in both projects.

The two projects are:

- **Understanding the importance of place in health inequalities**

  This five-year research project is investigating how the socioeconomic conditions of Victorian locations can influence health. The research will identify structural characteristics of places (such as the provision of public transport, opportunities for leisure time and physical activity and the provision of healthy foods) that can be modified to increase the potential for health promoting behaviour.

- **Environmental and individual determinants of physical activity and dietary behaviour**

  This project aims to determine why socioeconomic groups differ in their physical activity participation and food purchasing behaviours, by estimating the contributions of environmental, interpersonal and intrapersonal factors.

Female Life Expectancy at birth (LEB), ranking order and proportional change

VICTORIA Females (LGAs)	1992-1996 Rank	LEB 81.37		1996-1999 Rank	LEB 81.99		% change 0.8%+
Nillumbik	25	81.27		1	83.98	H	3.3%+
Manningham	3	82.88	H	2	83.63	H	0.9%
Monash	1	83.35	H	3	83.56	H	0.3%
Whitehorse	8	82.06	H	4	83.48	H	1.7%+
Yarra Ranges	7	82.19	H	5	83.32	H	1.4%
Bayside	5	82.49	H	6	83.27	H	0.9%
Baw Baw	29	81.23		7	83.26		2.5%
Moonee Valley	12	81.85		8	83.15	H	1.6%+
Melbourne	2	82.90	H	9	83.14		0.3%
Glen Eira	6	82.27	H	10	83.06	H	1.0%
↕							↕
Greater Bendigo	22	81.48		47	81.43		-0.1%
Gannawarra/Swan Hill	38	80.95		48	81.34		0.5%
Ararat/Northern Grampians/Pyrenees	54	79.56	L	49	81.06		1.9%
East Gippsland	34	81.04		50	81.02		0.0%
Bass Coast/South Gippsland/French Island	37	80.97		51	81.02		0.1%
Wellington	48	80.55		52	81.02		0.6%
Ballarat	52	80.22	L	53	80.92	L	0.9%
Mildura	35	81.02		54	80.83	L	-0.2%
Latrobe	56	79.40	L	55	80.39	L	1.2%
Melton	41	80.83		56	78.79	L	-2.5%

↕ Only LGA's with the highest and lowest life expectancy rates (1996-99) were included because of space limitations.
Full details are available on the burden of disease website at: http://hn01.dhs.vic.gov.au/bodw/t

Male Life Expectancy at birth, ranking order and proportional change

VICTORIA Males (LGAs)	1992-1996 Rank	LEB 75.61		1996-1999 Rank	LEB 76.50		% change 1.2% +
Manningham	1	78.58	H	1	79.26	H	0.9%
Whitehorse	4	77.54	H	2	79.18	H	2.1% +
Monash	2	77.96	H	3	78.94	H	1.3%
Bayside	3	77.56	H	4	78.75	H	1.5%
Boroondara	5	77.26	H	5	78.67	H	1.8% +
Casey	9	76.58	H	6	78.27	H	2.2% +
Nillumbik	10	76.58	H	7	78.26	H	2.2%
Stonnington	26	75.44		8	77.95	H	3.3% +
Whittlesea	7	76.77	H	9	77.90	H	1.5%
Glen Eira	6	76.80	H	10	77.75	H	1.2%
↕							↕
Melton	23	75.50		47	75.16		-0.4%
Buloke/Loddon/Central Goldfields	44	74.56		48	74.98	L	0.6%
Ballarat	49	74.04	L	49	74.92	L	1.2%
Latrobe	53	73.25	L	50	74.81	L	2.1% +
Mildura	46	74.38	L	51	74.58	L	0.3%
Port Phillip	55	71.93	L	52	74.58	L	3.7% +
Campaspe	32	75.19		53	74.54	L	-0.9%
Gannawarra/Swan Hill	45	74.45	L	54	74.47	L	0.0%
Yarra	56	71.68	L	55	74.37	L	3.8% +
Maribyrnong	54	72.99	L	56	73.97	L	1.3%

H indicates a life expectancy at birth significantly higher than the Victorian average
L indicates a life expectancy at birth significantly lower than the Victorian average
* indicates a statistically significant change in life expectancies between the two periods

Shopping Around for Food Ideas

Two food insecurity demonstration projects highlight food access issues in local communities.

Access to food is the basis for a healthy community. In Victoria, however, there are a significant number of people who aren't able to access the food they need. Addressing this issue is therefore a health promotion priority.

This is why VicHealth and the Department of Human Services have funded two projects, the Maribyrnong City Council Food Insecurity Demonstration Project, managed by Paul Greco, and the Yarra City Council Food Insecurity Demonstration Project, managed by Katrina Doljinan. Both began in 2001 to discuss the issue among local community and health agencies. They will recommend some innovative and long-term solutions to the problem in 2002.

Evidence of a problem with access to food has been around since 1995. A study undertaken by the Australian Institute of Health and Welfare revealed one in ten Australians aged between 19 and 24 reported running out of food at some time during 1995 and not having enough money to buy more.[1] In 2002 the problem still exists. 'As silly as it sounds, we've actually forgotten what it means to eat and to eat well,' said Greco. 'It's a pretty basic thing but the way in which community is structured at the moment we take that for granted.'

Maribyrnong ran a 'Food for Thought' forum in November 2001 attended by people from 22 health agencies. This identified those groups experiencing or at risk of experiencing food insecurity. Highlighted was that food security is inextricably linked to income security. So also was both the depth and hidden nature of the problem. 'In one Melbourne community the shopping strip has closed down, over a quarter of the population don't own a car, public transport is difficult and people are old and frail. All this combines to create a situation where access to fresh food is difficult for that community,' said Greco. That means food insecurity can apply to a wide range of groups in the community: asylum seekers, the homeless, people on low incomes, people with disabilities, the old and frail and people who are isolated.

Doljinan is targeting food insecurity as it exists among homeless people and people who are marginally housed in the City of Yarra. Her first step has been to engage with agencies that work with homeless people and to run focus groups with the homeless at their regular meeting places. These discussions have identified some of the determinants of food insecurity.

Food security: Access to food is a vital issue

Managers of both projects are attempting to identify practical long-term solutions at a local level. The ideas are plentiful, even if they're not necessarily new. Community gardens, re-educating people on creating fruit and vegetable plots and a mobile fruit and vegetable van are all possibilities. Changes in community structures and attitudes have meant that these ways of maintaining access to food have often been lost. Improving the food relief system or setting up a network of places that offer subsidised meals are other solutions. Examining how housing structures influence health outcomes and health behaviours may also be necessary.

Doljinan would like to develop a version of the café meals program. Clients have identified the type and variety of food they would like to be able to access and the environment they'd prefer to eat in. Traditional pubs have been well nominated. 'It's about keeping food supply reasonably costed and culturally appropriate,' said Doljinan.

Both have suggested cooking classes and shopping trips to markets as ways to create links between individuals within the community. Considering food access as part of community planning is also on the agenda.

The ideas are endless. Choosing the appropriate path is still to come. 'There are a number of areas with potential. We can't do them all so we're looking at what we can do within this project and what might work in the future,' said Doljinan.

[1] Australian Institute of Health and Welfare. A look at the population survey monitor. Food and Nutrition Monitoring News Number 5 December 1995.

For further information, contact
Paul Graco (Maribyrnong) on (03) 9688 0589
Katrina Doljanin (Yarra) on (03) 9411 3555.

Supporting Changing Communities

The Brotherhood of St Laurence is working toward an Australia free of poverty. Such an outcome would create significant improvements in population health. VicHealth Letter discusses the Brotherhood's approach to capacity building—one method of addressing inequalities in health—with Catherine Scarth, Manager of Community Services at the Brotherhood.

Capacity building is not just a buzz phrase. It can help to address inequalities in the community, and therefore impact positively on health. Capacity building, according to Catherine Scarth, Manager of Community Services at the Brotherhood of St Laurence, is about working in partnership with communities, thus allowing sustainable, long-term change to evolve. 'A community that's connected to each other, that cares about each other and that has a sense of control must be a healthier community,' said Scarth.

The Brotherhood supported the development of the InfoXchange program, Reaching for the Clouds, which put computers into the high-rise estate at Atherton Gardens. However, as Scarth explains, putting computers into the estate is only one small part of the project. 'The most important work is around engaging people to start thinking about, say, an intranet site. You need to engage the community about what goes on [the site] and hopefully at the end of the day they're putting on their own information. That's where, in terms of community building, using that type of technology is very exciting.'

The Brotherhood's Christmas Toy Program is another strong example of capacity building. Up until 2001 the Brotherhood ran two large toy shops as part of their Christmas Toy Program, making unwrapped toys available for eligible parents to select for their children. In 2001 the Brotherhood wanted to disperse the opportunity to do this to 20 separate locations around Melbourne. This, it was envisaged, would build connections for people in their local communities and save travel time. The Brotherhood's approach was not to go and set up 20 more shops of its own, however. Instead, it developed links with relevant organisations within a community, bringing with it its resources, model and the capacity to get the toys, then left the organisations already within the community to run the shops.

'In terms of what the Brotherhood does generally in the way of capacity building, it's not about us coming in saying we know everything, we're the professionals and we're here to help,' said Scarth. 'It's actually about acknowledging we don't have all the answers. We have a name and can raise resources but we share that capacity for the community to build upon in a way they think is important for them. It's not for us to have the solutions. We don't have them. For us it's about partnership. Sometimes it's difficult for communities. They're looking for leadership, however often it's about the way you engage and build that confidence back.'

The Brotherhood can advocate for social policy change on a national level or replicate a model that's worked well in other communities, while communities work within and for themselves. 'There are fantastic things happening around Australia for community development/community building. We need to share better and understand how we get those fantastic ideas to other communities,' said Scarth. 'If you want a healthy community you don't need to [just] talk about health services. There's a lot of parallels between health and other things.'

Inequalities and Social Entrepreneurship

What's the Brotherhood's current view on social entrepreneurship?

Scarth: It's a newish word in Australia but not in other countries. Right at the moment people are asking 'what does that mean?'. The word 'entrepreneurship' is challenging … Let's have a debate about what we want that to mean for us.

For me, it's about the person, whether they're a social entrepreneur or community leader or a person looking for a solution to things that are not working. An entrepreneur is a person who has the skills and the tenacity to bring together everybody around an issue to nut out what we do about it, who builds the social capital of a community and who is able to find local solutions. They shouldn't be discouraged.

We see it as a way to work differently. If we want an Australia free of poverty, we need to engage in a different way. We need to engage with all of the stakeholders in the community, whether they're local traders or whatever, because there needs to be a shared responsibility and a shared solution. That's where we try to engage the whole notion of social entrepreneurship.

For further information, contact Brotherhood of St Laurence (03) 9483 1183. Infoxchanges's website is at www.infoxchange.net.au

Community Engagement

Dr Robert Bush is currently on interchange with the Queensland Government from the University Of Queensland and is Executive Director for the Division. He spoke to *VicHealth Letter* about some of the Division's objectives and the issues that are important in involving communities in decision-making.

It is a perennial challenge for health promoters and, often, politicians: how do organisations, bureaucrats or individuals target groups and communities, make sure they're involved in decision-making processes and create, alongside them, policies and programs that meet a community's real, rather than perceived, needs? How can appropriate programs to address inequalities be set up? How can a wide range of people be involved in decision-making rather than the majority of thoughts just be emanating from those individuals in higher socioeconomic groups?

Within the Queensland Department of Premier and Cabinet, the Community Engagement Division has begun to tackle these questions. The Community Engagement Division, a recent initiative of the Queensland Government, is designed to improve the quality of decision-making and the connection between government, business and the community. Dr Robert Bush is currently on interchange with the Queensland Government from the University Of Queensland and is Executive Director for the Division. He spoke to *VicHealth Letter* about some of the Division's objectives and the issues that are important in involving communities in decision-making.

'We need to strengthen the representative democracy process, the participatory democracy process and capacity building across the social, economic and environmental portfolios,' said Bush.

Community engagement is still an idea in its infancy in terms of practical application but it has relevance for health promotion as well as the political process. It has the potential to involve a diverse range of people and communities in the process of decision-making. This can impact upon health both directly and indirectly. Directly, it may see communities developing policy appropriate to their specific needs, such as the Cape York communities are currently attempting to do in partnership with the Government. Indirectly, community engagement may impact upon health by improving levels of social inclusion. Including people in the process of decision-making creates greater opportunities for improved mental health (sometimes just by being involved in a good process) and for improved systems and programs to be developed to address the diverse range of health needs within the wider community. 'By involving people you get the system that directly relates to the community you are working with,' said Bush.

Bush admits it's a long process engaging with communities, but worthwhile. 'It requires a certain ability to work to build plans with communities rather than starting with the design of the plan and then placing it upon those communities.'

Of course, involving people presents real challenges, particularly in relation to resolving inequalities and obtaining a real and diverse spread of opinions and opportunities. Dr Bush admits this is a very serious challenge for the Community Engagement Division. 'It's why one of our intended outcomes is better social inclusion. We do know that if you set up a process of working with communities, then people who generally have more money, or who have a better education, will be the first people who become involved.'

This information has been borne out by a survey commissioned by the Division which shows the shape and prevalence of participation in the State by region. The demographic profile of the current participants shows they are people within higher socioeconomic levels.

Bush says that the process of engagement is about creating a link between communities, local decision-makers and Parliament which are long-term. Involved people understand how deliberations with Government proceed and what it is possible and not possible to achieve in a representative democracy. The Division has therefore established some mechanisms and opportunities to enable all people to be involved. This involves deliberation, not opinion. 'The other challenge is how do you create a public administrative system that copes with deliberations? That requires building relationships and improving ways of working through different complex issues,' said Bush. 'Involvement by a diverse range of people requires training people and producing new processes or ways of deliberating with people about strategic policy. For example, the Division has responsibility for establishing the E-Democracy initiative. This involves using e-technologies to make the Parliament more accessible to citizens and building a web-based capability for government–community deliberations about significant policy issues.'

Further information about the Cape York Justice Study and the Cape York Coordination Unit can be obtained at http://www.premiers.qld.gov.au/about/community/studies.htm. For further information about community engagement, see http://www.premiers.qld.gov.au/about/community/index.htm.

One in, all in: Leads to more equal outcomes

A Quick Question

Do you see community engagement as actually improving the wellbeing of the community or individuals within the community because of their involvement in decision-making processes?

RB: In the health field we tend to talk about better wellbeing in terms of individual health status. Certainly that is one outcome that might occur. There is a range of other outcomes that occur by improving the democratic process, however.

We know that if people are involved in deliberations around services and policies they have a sense that it is a legitimate system and that theirs is a legitimate voice. Community engagement also builds solidarity and social capital. It is simply easier to deliver good quality services if people have confidence and trust in those services. Better social justice is another outcome. If people have an idea about who gains and who doesn't gain in terms of health inequalities, and what we, as a State and a people, can do better, we're likely to get better social justice. In practical terms, it should not be acceptable that we have the most appalling conditions in some Indigenous communities. That's not just an issue for Indigenous people but for all people in the State.

Better social inclusion is another outcome. Individuals, groups and organisations have better and fairer input into the way we treat, for instance, the health system. Consultation processes around health issues tend to be directed at key service delivery stakeholders. There is a rising interest in whether a key stakeholder approach alone really captures the voices of people using those services. Community engagement can ensure a wider variety of diverse voices are heard during the process of policy and service development.

The community engagement approach therefore presents a series of outcomes that are well beyond the notion of simply better health status—for example, better democracy, solidarity, social justice, social integration and health systems.

Community Engagement in Practice

In Cape York in Queensland's far north, community engagement processes are underway in order to address the substantial social, health and economic problems that exist in the area and within communities in the region. Under the guidance of the Premier, the Cape York Coordination Unit has been set up to deliver on the Government's stated policy commitments. The Tony Fitzgerald report—*The Cape York Justice Study*—commissioned by the Queensland Premier, Peter Beattie, outlines in detail the current state of affairs and the possibilities for community engagement practices to address the social and health issues existing with the community.

Community Engagement Division Objectives

1. **Learning together by showcasing good practices**
   Queensland's Modernising Democracy showcase
2. **Reaching out to citizens, reaching out to government**
   Building the new ways of engagement for informed public judgement on complex issues faced by citizens and governments
3. **Building the capacity for local solutions**
   Building Queensland's regions so that local solutions use the unique and resilient capabilities of regional communities and government agencies
4. **Delivering on diversity**
   Engaging Queensland's cultural diversity for sustainable social, cultural and economic development
5. **Putting democracy online**
   The Queensland E-Democracy three-year trial

Koori Health: Overcoming Inequalities.

This article was written for the *VicHealth Letter* in consultation with Associate Professor Ian Anderson at the VicHealth Koori Health Research and Community Development unit.

Health inequalities are most marked between Indigenous and non-Indigenous Australians. Aboriginal and Torres Strait Islander peoples have a demonstrably poorer health status than non-Indigenous people across a range of measures. This health disadvantage begins at an early age and continues through the life cycle. It reflects the broader social and economic disadvantage faced by Aboriginal and Torres Strait Islander Australians.[1]

Victorian Aboriginal men and women have a life expectancy which is 8 to 18 years lower than the State average. Cardiovascular disease (including heart disease), respiratory diseases (including pneumonia, asthma and emphysema), injuries (including traffic accidents, suicides and homicides) and endocrine diseases (especially diabetes) are key contributors to ill-health and excess mortality in Aboriginal people.[2]

A comparative analysis of Indigenous health trends among settler colonial states such as New Zealand, Canada, the United States and Australia, which share broadly similar historical and contemporary social contexts, underlines the issue for our community. Analysis of trends in Indigenous mortality in these nations, apart from Australia, demonstrates significant health gains, particularly during the 1960s and 1970s, gains that have narrowed the health gap relative to the settler population. With the exception of infant death rates, we are unable to point to similar trends in health gain for Indigenous Australians.[3]

Indigenous Australians are disadvantaged compared with other Australians in social and economic measurements relating to education, income and housing and are statistically more likely to use drugs and other harmful substances; it is likely that these disadvantages contribute to nutritional disadvantage as well.[4] Evidence shows that socioeconomic status is linked to health status.

There have been significant efforts undertaken by Australian governments and Indigenous communities over the last 15 years to improve the capacity of Indigenous health care. From implementation of the National Aboriginal Health Strategy (NAHS) in 1994 to the current blueprint of Aboriginal Health Framework Agreements there has been an increasing focus on developing the foundation for collaborative efforts to improve health outcomes. The challenge remains to continue to develop these collaborative efforts and in particular develop partnerships with Aboriginal and Torres Strait Islander communities and community structures.

Health care reform is a critical component of a whole-of-government strategy to effectively address the challenge of Aboriginal and Torres Strait Islander health. Reform in Indigenous primary health care should aim to provide the range of services required as per health need and to appropriately integrate the delivery of such services in order to achieve broader population health goals.

Within the current policy framework there are domains of policy and strategy development that constitute developmental themes. These are:

- developing the infrastructure and resources necessary to achieve comprehensive and effective primary health care for Indigenous peoples;
- addressing some of the specific health issues and risk factors affecting the health status of Indigenous peoples;
- improving the evidence base which underpins the health interventions; and
- improving communication with primary health care services, Aboriginal and Torres Strait Islander peoples and the general population.[5]

The development of effective health care for Indigenous Australians rests on the development of an appropriate health workforce. The mix of skills necessary for effective Aboriginal primary health care includes competencies in cross-cultural practice, chronic illness management, integrated population and clinical care service delivery and the provision of emotional and social health services as well as an understanding of the relationship between health care provision, community development and self-determination.

There is also a need to develop evidence that guides Indigenous policy reform and for such knowledge to be developed in a way that makes an impact on policy development and health care practice.

While health reform is critical for indigenous health it needs to be linked to a broader whole-of-government strategy to improve housing, education, employment and economic outcomes for indigenous Australians.

However if we are to achieve an appropriate systemic response to the challenge of Indigenous health this must be based on a critical understanding of the historical, political, economic and social forces that have caused the health inequalities to develop.

Snapshot of Inequalities in Health

- Aboriginal and Torres Strait Islander peoples experience the onset of disease at earlier ages and have shorter life expectancies than the general population.
- Using available data and adjusting for different age structures of the Indigenous and non-Indigenous populations, it is apparent that in 1998–99 Aboriginal and Torres Strait Islander peoples were about twice as likely to be hospitalised as people in the general community.
- Type 2 diabetes tends to occur at younger ages in the Indigenous population than in the non-Indigenous population.
- Estimated life expectancy for both Indigenous males and females was 19 to 20 years lower than for other Australians (based on registered deaths data from Queensland, South Australia, Western Australia and the Northern Territory).[6]

Improving Koori health: a challenge for everyone.

VicHealth Koori Projects

VicHealth, under the Mental Health Promotion Plan, and in partnership with Victoria's Koori community, has developed projects to improve the health and wellbeing of the community.

The Victorian Koori Leadership for the Future Network development of future leaders will play a significant role in the wellbeing of communities as they engage in partnerships with a variety of sectors to improve and maintain the emotional and spiritual wellbeing of Koori communities.

The Victorian Koori Imaging Project is developing and implementing a communications strategy to give voice to and promote Aboriginal Victorians. Positive Koori images will foster an environment in which individuals, families and communities can develop coping skills to deal with the challenges facing Koori culture and communities. This will have a positive impact on their spiritual and emotional wellbeing.

Victorian Koori Community Leadership Projects provide leadership training for young Kooris, mentoring by senior community members, and support and resources to develop leadership skills through the planning and implementation of community activities. This will improve spiritual and emotional wellbeing in both the short and long-term.

VicHealth Koori Health Research and Community Development Unit is building the evidence base by taking a partnership approach to research and academic teaching by actively encouraging and supporting Aboriginal participation.

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3. In part, it is more difficult to make trend analyses within the Australian context due to the historically poor quality of Indigenous health data. Nevertheless, for the period 1990–94 the Australian Indigenous all-causes mortality rate was 1.9 times the Maori rate, 2.4 times the United States rate and 3.0 times the All-Australian rate.

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GPs and Inequalities

Lucio Naccarella and Dr John Furler, Department of General Practice, The University of Melbourne, are finding ways for GPs to assist in addressing inequalities in access to health services.

General practitioners (GPs) are the point of first contact with health services for the majority of the population in Australia. Concern for equity of access to high quality services must be core business for general practice. Suggestions for what GPs can do about health inequalities include:

- understand that inequalities do exist, and help clarify them locally;
- understand that any force on health, even a social force, lies within their professional domain;
- develop clinical practice sensitive to social class;
- identify ways of limiting the effects of health inequalities in their clinical practice;
- participate in research that aims to better understand how social class can impact on the outcome of care and the effect of interventions aimed at reducing inequalities;
- participate in alliances aimed at producing healthy environments (workplaces, communities, schools, cities); and
- raise the issue of health inequalities in the social and political agenda through strategic partnerships with the media.[1]

Currently, several policy initiatives exist that support GPs in their day-to-day work and in working with other sectors and community groups to address health inequalities. These include the Medical Benefits Schedule items (for example, Enhanced Primary Care) and the Divisions of General Practice program. The work of the Joint Advisory Group which focuses on the increased role of general practice in population health has also provided the opportunity for discussions about health inequality.

In 1996 a research consortium was formed to look at issues around engaging general practice with health inequalities.

The consortium members are:

- the University of Melbourne Department of General Practice;
- the Centre for Health Equity Training Research and Evaluation; and
- the University of NSW School of Community Medicine.

The consortium's work program has included literature reviews; workshops with GPs, Division staff and other stakeholders; interviews with GPs; development of guidelines; reviews of Division projects and strategic plans; and a national survey of Divisions of General Practice. This work has explored GP attitudes, described barriers and enablers, described examples of GPs and Divisions addressing health inequalities and promoted a debate among GPs and Divisions on this issue.

Several issues have consistently emerged from this work, including:

- **a need for leadership**—the profession's leaders, by acknowledging the importance of a concern for equity of service provision, can play a vital role in assisting GPs in this work;
- **a need for a language of health inequalities in general practice**—how do we engage the target group to think about Inequalities;
- **a need for good quality data to help identify disadvantaged groups in practice and Division populations and commit resources to them**—this may include collecting data on the socioeconomic status of patients more systematically and using it to audit clinical care;
- **a need for structural support at the practice level**—this may involve building capacity of GPs and Divisions to work collaboratively, developing skills in needs assessment as well as ensuring resources such as the Practice Nurse Program are targeted to areas of high need; and
- **a need for multilevel action in general practice.** Again, building capacity in Divisions to work across sectors is important. Advocacy for healthy environments and social and political action are clear examples of this.

Consortium members are currently working with the Royal Australian College of General Practitioners to examine opportunities to build an approach to health inequalities into its policies, programs and activities, including its GP training and quality assurance programs. This work has revealed the importance of providing high quality training experiences in areas of disadvantage, as well as numerous opportunities for building a concern with equity into professional development and practice accreditation programs.

Members of the consortium are coordinating the Health Inequalities Research Collaboration (HIRC) Primary Health Care Research and Development Network that aims to provide leadership on health inequality through primary health care (PHC), develop consensus of priority issues for the PHC Network, build capacity of PHC health equity research and development and provide a mechanism for information exchange and support.

For further information contact, Lucio Naccarella at University of Melbourne on (03) 9496 4428

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Health Care and Refugee Health Inequality: Possibilities and Limitations

Kim Webster, Project Officer, Workforce Development Project — Access Pathways for New Arrivals, Victorian Foundation for the Survivors of Torture

Programs and structural changes can improve the health status of refugees

As is the case with other groups on the negative side of the health divide, fundamental solutions to refugee health inequality lie in fostering a safe, tolerant and welcoming environment and in improving access to housing, income, meaningful employment and social support. While many of these solutions are outside the immediate ambit of the health care system, improving the accessibility, quality and sensitivity of health care is nevertheless an integral part of an overall health equity strategy.

Since its establishment in 1988, the Victorian Foundation for Survivors of Torture (VFST), a counselling and support agency for people from refugee backgrounds, has developed a multifaceted approach to this endeavour, involving work with new refugee arrivals, refugee communities, health care professionals and government. This was complemented this year with its contribution to the Health Access Pathways and Refugee Health and General Practice Development Projects.

Empowering new refugee arrivals

The Health Access Pathways Project—a collaboration of the VFST, the Adult Multicultural Education Service (AMES), new arrival communities and service providers—involved the development of a curriculum workbook titled *Healthways*, for use in adult English as a Second Language classes, along with booklets in eight community languages titled *Making a Healthy Start in Australia*. These resources were developed following consultation with new arrivals and those working with them and were designed as companion publications to orient new arrivals to the Australian health care system. The booklets allow new arrivals to acquire complex conceptual information in their first language while learning the language required to access health services through corresponding English language exercises in Healthways. With some 80% of new arrivals enrolling in language classes, this approach will ensure maximum program reach. The booklets will also be distributed directly to new arrivals by counsellors at the VFST and other health care providers.

Promoting responsive health care

Most Australian health care providers require additional support and information to respond to the health care needs of those affected by war and civil conflict. Recognising that informing new arrivals about accessing health care was but part of the solution, *Promoting Refugee Health: A Handbook for Doctors and Other Health Care Professionals Caring for People from Refugee Backgrounds* was developed. This publication provides information to assist health care providers to identify people from refugee backgrounds, to better understand their health and patient care needs and to provide sensitive care.

The Refugee Health and General Practice Development Project was specifically targeted to General Practitioners (GPs), recognising their important role in post-arrival health care. New arrivals are no longer offered routine health care on arrival. Pre-arrival screening is limited and selective being conducted primarily to identify serious communicable disease. The project was again a collaborative venture, involving general practice organisations and mental health and infectious disease experts. It undertook a range of strategies, including developing health assessment guidelines which were published in *Caring for Refugee Patients in General Practice: A Desk Top Guide*, establishing a network of GPs with an interest in refugee health care, and conducting professional development programs and a small scale study aimed at identifying and addressing practical barriers to refugee health care. The project is currently being documented as a resource so that it can be replicated with other GPs in Victoria and nationally.

Addressing systemic barriers

Some solutions lie in systemic change in the Australian health care system itself (for example, improving interpreter access or better remunerating doctors for the longer consultations required to accommodate the complex health and patient care needs of new refugee arrivals). Consultation and research conducted as part of the projects, while providing a basis for developing specific project resources and programs, were designed with an eye to identifying and documenting these systemic barriers. This information will serve as important basis for the ongoing work of the VFST and its partners to advocate for a more equitable health deal for new arrivals from refugee backgrounds.

All involved

The Health Access Pathways Project was jointly funded by VicHealth, the VFST, AMES and the Department of Human Services, Western Metropolitan Region. The Refugee Health and General Practice Development Program was implemented by the VFST on behalf of five Divisions of General Practice, with the Western Melbourne Division of General Practice being the lead agency. It was funded by the Commonwealth Department of Health and Aged Care. For further information, visit www.survivorsvic.org.au

For further information, contact Kim Webster on (03) 9388 0022.

Working For Ages

Bernadette Fallon is coordinator of the Working for Ages—Active Strategies for a Productive Workforce project.

VicHealth's *Mental Health Promotion Plan* identified participation in the workforce as a key determinant of older people's mental health. Discrimination against older people can create health inequalities by excluding a sector of the population from participating independently in economic activity—a significant social determinant of health.

To address this issue, the Working for Ages—Active Strategies for a Productive Workforce project, a partnership between VicHealth, the Department of Human Services and the Equal Opportunity Commission of Victoria, was launched in August 2001.

The Working for Ages project is designed to increase awareness of issues surrounding an ageing workforce, dispel some of the myths associated with employing older workers and create a better understanding of the benefits that can flow to employers and the community from hiring mature age workers.

The project's aims are to:

- develop educational and information products to raise awareness and improve adherence to equal opportunity legislation;
- debunk ageist stereotypes in employment;
- explore the capacities of workers over 45 and promote the positive contribution they make in employment;
- study the demographic and economic impacts of an ageing population and its likely impact on business;
- develop a forum for feedback to the various levels of government on policies related to an ageing workforce;
- develop and disseminate international and Australian examples of business best practice; and
- host regional forums in the east and west of Melbourne.

Bernadette Fallon from the Equal Opportunity Commission Victoria is responsible for the project. 'The project emphasises the positives of what mature aged people can do, and how they can be productive members of society contributing enormously to society through work and therefore achieving better physical and mental health outcomes,' said Fallon.

Fallon has developed four fact sheets presenting an overview of the issues and evidence to challenge stereotypes about older workers. She has also developed presentations that provide information to three specific groups: mature aged workers, employers and recruitment organisations.

Fallon is also building two regional networks in Melbourne—one in the east and one in the west. The Western Region held its first forum in November 2001 and followed with another in January 2002 identifying some of the major issues for mature aged workers. Access to dignified and well-paid work, finding new ways for older people to be employed, flexible work options, a variety of training opportunities that provide for cultural diversity and are inclusive of all people and strong communication of the message were all topics that the forum decided were worthy of further investigation. The Eastern Region's first network meeting is being held in February 2002.

'The best thing about the project is that it concentrates on the positives of mature aged people,' said Fallon.

Fast Facts

- Workers over 45 are the fastest growing sector of the workforce.
- Baby boomers born in 1947 will be 55 years old in 2002.
- Projections suggest that by 2005, 35% of the workforce will be aged over 45.
- Skill shortages are likely to result if Australian business does not utilise the skills and talents of workers over 45.

A Work in Practice

Alan Banks, 76 years old (father of 14 and grandfather of 24, and still working)

'People keep ringing me for advice on investments. I feel needed and that's not a bad feeling, is it?'

For further information, contact Bernadette Fallon, Project Officer, Working for Ages Project, Equal Opportunity Commission Victoria on (03) 9281 7118 or at bernadette.fallon@eoc.vic.gov.au.

Wanted: Healthy Men

La Trobe University's Mr Rick Hayes says initiatives to improve men's health have grown since 1995 but there is still a lot of work that can be done.

A few years ago, statistics from the Australian Institute of Health and Welfare would simply be accepted: men have worse health outcomes than women. Today, the health promotion workforce in Victoria is 'clued in' to the wider contextual nature of the lives and circumstances of men, women and children. Interventions today seek to create partnerships across a number of sectors. Agencies that are looking for ways to promote men's health are also working much more collaboratively with the men themselves to discover what their concerns are and what capacity both the men and the agencies have to address these.

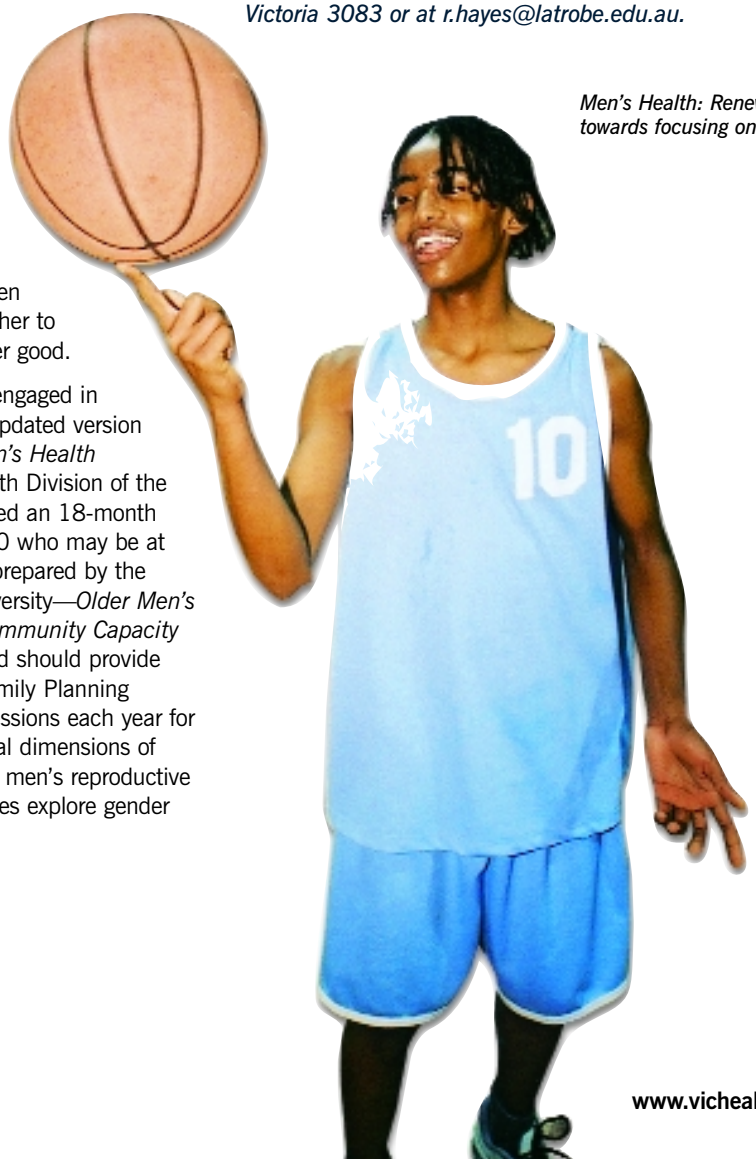
There are number of reasons for the tremendous growth in concern for men's health promotion since 1995. First, the issue has been widely covered in the media as high-profile men in business, sports and entertainment have revealed their personal struggles and triumphs. Governments have also increasingly recognised the social costs of failing to address men's health issues. Federal and state governments have sponsored major forums and conferences, sought to develop men's health and gender equity policies, funded various programs and projects and helped in the creation of men's health research programs and centres. As well, various health professionals have realised the need for better training and resourcing, which has lead to an increased call for standards, protocols and guidelines. Finally, groups addressing issues relating to the health and welfare of both men and women have been willing to work together to find common ground and support the greater good.

There is growing support for the workforce engaged in this activity. VicHealth has republished an updated version of *Developing Strategic Frameworks for Men's Health Promotion*. The Aged Care and Mental Health Division of the Department of Human Services (DHS) funded an 18-month project to understand issues for men over 50 who may be at risk of suicide. The final draft of the report prepared by the Lincoln Gerontology Centre at La Trobe University—*Older Men's Access to Health and Welfare Services: Community Capacity Building in Action*—has been submitted and should provide valuable insights into working with men. Family Planning Victoria continues to hold several training sessions each year for nurses and general practitioners on the social dimensions of men's health as well as specific sessions on men's reproductive health. Both La Trobe and Deakin Universities explore gender related issues in their public health courses.

The community has also benefited from the growth of men's health promotion activities such as Men's Health Week celebrated each September. In the past year, Andrology Australia (The Australian Centre for Excellence in Men's Reproductive Health, Monash University) promoted men's health through a creative partnership between the Divisions of General Practice and Coles-Myer that distributed literature and raised awareness through the sale of specially designed Father's Day cards.

Primary Care Partnerships and the funding of health promotion short courses by the Department of Human Services have also helped link people interested in men's health promotion. Local councils, community health centres, neighbourhood houses, migrant resource centres, schools and church welfare programs are all also increasingly involved in strategically planning for and engaging in issues relating to the health of the men with whom they work, live and play.

For further information, please contact Rick Hayes, Lecturer, School of Public Health, La Trobe University, Bundoora, Victoria 3083 or at r.hayes@latrobe.edu.au.



Men's Health: Renewed efforts towards focusing on men.

*DALY's - Disability Adjusted Life Years

A Silent Epidemic of Inequality

Social research into people affected by Hepatitis C undertaken by Professor Sandy Gifford of Deakin University has revealed a silent epidemic of Inequality.

Recently, the Anti-Discrimination Board of New South Wales completed an enquiry into hepatitis C related discrimination. The key conclusion was that the evidence '… clearly demonstrates that hepatitis C is a highly stigmatized condition and that discrimination against people with hepatitis C is rife' (p. 12).[1]

Hepatitis C is the most frequently reported notifiable infection in Australia, with an estimated 160 000 people currently affected by the virus and many more likely remaining undiagnosed.[2]

Living with hepatitis C brings a host of social and physical consequences. Socially, people experience stigma and discrimination by health care providers, family and friends as well as in the workplace. Physically, people live with chronic fatigue, nausea, aches and pains, liver swelling and a general feeling of being unwell. They are thus unable to participate in the ebb and flow of everyday life. Despite the epidemiological, clinical, social and psychological evidence of the great impact of hepatitis C on population health, this epidemic remains largely invisible. This contributes to continuing inequalities in access to health care, the right to basic social goods and being able to enjoy full participation in social life.

The Social Research Program into Hepatitis C and Related Blood-Borne Viruses at Deakin University has been carrying out a range of studies on the impact of this condition on individuals and communities. This research highlights the range of social and health inequalities experienced by those affected by this silent epidemic. The research is being undertaken in collaboration with a range of community and peer-based organisations (including the Victorian Hepatitis C Council, the Australian Hepatitis Council and the Australian IV League) and other academic institutions (ARCSHS at La Trobe University and NCEPH at the Australian National University) and funded by the NHMRC. Studies include a recently completed large-scale survey of the social and health needs of women affected by hepatitis C; a similar survey of men currently in process; a qualitative study with women from Cambodian, Vietnamese and Laotian backgrounds; and a study of discrimination in health care settings.

The research findings emerging from the studies clearly paint a picture of a silent epidemic of inequality. For example, in our recently completed survey of 462 women with hepatitis C in Victorian and the ACT:[5,6,7]

- Sixty-five per cent had only completed up to year 11 in school, 59% were living on benefits and nearly half (46%) found it very difficult to meet the costs of one or more of the following: rent, utilities, clothing, transport and food.
- Close to half (48%) described their health as only fair or poor; this is a higher proportion than among most women in Australia. Age-related self-assessed health status was also significantly lower than Australian norms, as were SF-12 physical and mental health scores. The SF-12 physical and mental health scores were highly correlated, indicating a significant physical *and* mental health burden associated with hepatitis C.
- Nearly half (48%) said that they received less favourable treatment from health professionals because of their hepatitis C. Women who currently injected drugs were more likely to have reported negative treatment, especially by dentists, nurses and pharmacists. Australia is one of the first countries to develop a national strategy regarding hepatitis C and currently there are a number of public health initiatives aimed at developing effective prevention, support and care strategies.[3]

Hepatitis C is one of the many inequalities that challenge population health in Australia. Currently, those most at risk are people who experience a range of social disadvantages including unemployment, poor educational opportunities, lack of appropriate housing and the social stigma of injecting drug use. Equally, those living with this condition experience a range of inequalities in relation to access to primary health care, appropriate treatment by health care professionals and participation and social marginalisation in participation in the wider social life of the community. It could be argued that hepatitis C is one of the more insidious inequalities, in part because of its invisibility. Yet, those affected know very well how to begin to address these challenges. One of the responsibilities of population health is to join in partnership with affected communities to begin to make this silent epidemic visible.

More information about this program can be accessed at: http://www.hbs.deakin.edu.au/hepc/

Background

Hepatitis C is a blood-borne virus and about 80% of infections are attributed to injecting drug use. The remaining 20% of infections are attributed to blood products (prior to 1990 when screening of the blood was introduced) and other forms of blood-to-blood contact. There is no vaccine for hepatitis C. Of the people infected, about 25% get rid of the virus with the remaining 75% going on to live with a chronic illness.[4]

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All in: Hepatitis C is an illness people learn to live with.

Challenge: Hepatitis C is quietly stigmatising people

2002 Fellowships and Scholarships

VicHealth has awarded one Senior Research Fellowship, four Public Health Fellowships (one jointly funded by VicHealth and the Department of Human Services) and two Public Health Research PhD Scholarships to commence in 2002.

Senior Research Fellowship

This Fellowship was awarded to Dr Anthony LaMontagne, Monash University, for the project titled 'Integrated, community-based approaches to health promotion for Victorian blue-collar workers'.

Public Health Research Fellowships

Four Fellowships were awarded to:

- Dr Pascale Allotey, The University of Melbourne, for the project titled 'Promoting long-term health and wellbeing in refugees and asylum seekers: informing policy and practice';
- Dr Lyndal Bond, Centre for Adolescent Health, for the project titled 'Implementing and evaluating system-level change to improve adolescent health and wellbeing'. This Fellowship is jointly funded by VicHealth and the Department of Human Services;
- Dr Jo Salmon, Deakin University, for the project titled 'The relationship between the built, social and policy environment and physical activity in families'; and
- Dr Kevin Rowley, The University of Melbourne, for the project titled 'Interventions to improve cardiovasular health in Aboriginal people'.

VicHealth Public Health Research PhD Scholarships

Two Public Health PhD Research Scholarships were awarded to:

- Ms Clare Hume, Deakin University, for her project titled 'The influence of the family environment on children's physical activity' (Clare will be working with Dr Jo Salmon); and
- Ms Nicky Welch, The University of Melbourne, for her project titled 'A study exploring the cultural basis of drug and alcohol consumption and health outcomes in a rural centre'.

Together We Do Better Campaign Enters New Phase in 2002

The Together We Do Better campaign, which VicHealth has conducted since June 2001 as part of its role to promote mental health and wellbeing, concentrates with its latest material on raising awareness of the health effects of bullying and social isolation. A limited number of posters produced as part of the media and advertising campaign are still available.

Bullying as a Mental Health Issue—Groups Join Forces

On 3 February 2002, during the 'back to school' rush, VicHealth joined forces with the Department of Education, Employment and Training (Social Competencies Unit), the Centre for Adolescent Health, Kids Help Line, the Alannah and Madeline Foundation and Mind Matters to raise bullying behaviour as a significant mental health issue for schools and the community. School is a microcosm of the greater community, and this group is committed to highlighting what is and what can be done to address bullying behaviour in our schools.

Bullying in our schools is a long-term mental health issue. Research from the Centre for Adolescent Health shows that up to 30% of depression in young people might be prevented if we could stop bullying. Young people who are victimised are three times more likely to be at risk of having depressive symptoms when compared to those not reporting such experiences.

Research also highlights that schools with a supportive and inclusive 'school community' where students feel they belong and are appreciated are less likely to have high levels of bullying behaviour.

What can we do to address bullying behaviour? What is needed is a community response, just as schools in Victoria have adopted a whole-of-school approach to create positive and healthy environments for learning. In a survey of 600 Victorians aged between 18 and 65—*Victorians' Attitudes Towards Bullying*—95% of respondents said that bullying was never acceptable. Failing to address bullying behaviour sends the message that it is an acceptable behaviour within our schools, homes, sporting groups, workplaces and community. It misses the opportunity to build positive, respectful and supportive relationships.

If we are serious about addressing bullying behaviour, it is important that we work together as a community to ensure that it is not tolerated—Together We *Can* Do Better.

Together We Do Better Website

The Together We Do Better website—www.togetherwedobetter.vic.gov.au—provides all the latest news from the campaign and information on specific events relating to mental health promotion. It also provides useful links to a range of organisations that are able to assist in the area of mental health promotion.

VicHealth Awards 2001

VicHealth held its 2001 Annual General Meeting at the Footscray Community Arts Centre last December. The meeting was attended by the Hon. John Thwaites, Minister for Health; Mr Robert Doyle, Liberal Spokesperson for Health; Ms Marion Crooke, CEO of Footscray Community Arts Centre; VicHealth Chairman, Professor John Funder; VicHealth CEO, Dr Rob Moodie; and the Footscray Mayor, Mr Joseph Cutri. Each year, VicHealth presents awards to recognise and thank our partners who have provided valuable support and made outstanding contributions to health promotion in Victoria.

2001 VicHealth Excellence in Health Promoting Research Award

Winner: *The Centre for Adolescent Health—The Gatehouse Project*

The Gatehouse Project focuses on building positive social relationships at school. It aims to promote emotional wellbeing and to prevent behavioural problems by working to strengthen a sense of positive connection to the school. This innovative research project now involves over 60 Victorian secondary schools and is continually creating new partnerships and building on the Gatehouse design. The Gatehouse Project has informed health promotion research by describing a rigorously evaluated intervention that has the potential to substantially reduce the morbidity associated with the use of tobacco, alcohol and illicit drugs by young people. The project has provided an understanding of the influence of social environments on emotional wellbeing and other important health risk factors of adolescents.

Highly Commended: *Monash University Accident Research Centre—Victorian Injury Surveillance and Applied Research Systems Project*

The Monash University Accident Research Centre has been working on the Victorian Injury Surveillance and Applied Research Systems Project for 13 years. During the period 2000–2001, several new research projects were initiated including an investigation of scooter injuries and temazapam injection monitoring.

2001 VicHealth Excellence in Health Promotion Award

Winner: *The Victorian Country Football League—Health Promoting Sponsorship Package*

This project generated a radical change in Victorian country football through the development and implementation of smoke-free policies across all leagues and clubs in only one year. The program works to dramatically improve the environment at clubs and leagues across the State, in keeping with a truly healthy and happy family environment. The SmokeFree promotion has been the most consistently visible program throughout the Victorian Country Football League in its history.

Winners of 2001 VicHealth Excellence in Health Promotion Awards.

Highly Commended: *Ballarat and District Aboriginal Cooperative—Makin Pitchas Project*

An aim of this project was to engage local Koori youth in positively exploring mental health issues that may affect their lives. From various workshops, four short films were produced to develop the filmmaking skills of the youths involved. The films were also used to raise awareness of the specific mental health problems of young Indigenous Australians.

2001 VicHealth Health Promotion through Community Participation Award (Section 1)

Winner: *Warrnambool Alternative School—Traditional Games Project*

The Traditional Indigenous Games Program focused on fostering a relationship between sporting activity, Indigenous culture and identity within Warrnambool and District Primary Schools. Physical Education teachers and student leaders were instructed in the delivery of a range of Indigenous sporting and recreational activities, culminating in the coordination of an interschool traditional Indigenous games competition. The project provided school students and staff with insight into, and knowledge of, Aboriginal and Torres Strait Islander culture, as well as providing Koori participants with an avenue to celebrate their cultural traditions.

Highly Commended: *Surf Coast Shire—Torquay High Tide Festival*

The Torquay High Tide Festival is the only community arts festival in the Surf Coast Shire. Since 1995 it has provided the local community and visitors with an annual event. The main Festival program is a free event, with some sideline events organised to raise funds for local needs. Service groups use the Festival as a promotional tool and over 100 local primary school children are involved in a range of ways. The youth stage has been developed to increase the participation of local youth, holding specific events such as the FREEZA Skate Rave.

2001 VicHealth Health Promotion through Community Participation Award (Section 2)

Winner: *The Polyglot Puppet Theatre—High Rise Project*

The Polyglot Theatre Group worked closely with the residents of the Carlton high rise housing commission flats to create 'High Rise', a visual outdoor puppet performance created from the resident's talents and stories. Incorporating the architecture of the site, this project opened the flats to a wider public, allowing residents, especially children, to express the way they live to people who perhaps have little understanding about their lifestyles and cultures.

Encouragement Award: *The Bouverie Centre—Breaking Through Project*

The Breaking Through Project aimed to address the needs of same sex attracted youth through developing a preventative, family inclusive, educative and therapeutic school-based approach to change. This approach sought to minimise discrimination and harassment related to gender, sexual orientation and diversity. The project provided a model for rural schools (students and staff), families and their community to work in partnership to support tolerance of diversity in all aspects of school life and promote better mental health for same sex attracted young people.

2001 VicHealth Innovation in Health Promotion Award

Winner: *Somebody's Daughter Theatre Company—Breaking the Cycle Project*

This project involved female prisoners and ex-prisoners working with professional artists to produce and perform the play 'So Full of Brave' and exhibit their artwork. The art exhibition (produced from classes that were conducted in prison) and the play took place at the Victorian Arts Centre. The project also involved a series of interactive workshops and discussions within communities across Victoria. The project worked to raise community awareness of underlying issues leading to gambling, drug addiction and their consequences. The project also aimed to motivate individuals who find themselves on self-destructive journeys to make positive and empowering changes in their lives.
All the women involved in this project expressed a sense of achievement from the performance and art exhibition.

Highly Commended: *Whitelion Inc.—Whitelion Project*

The Whitelion Project works with young people who reside in the juvenile justice system. The project aims to improve their self-esteem and confidence and provide healthy links to the community and opportunities to achieve financial independence after release from custody.

New VicHealth Board Member

VicHealth welcomes Ms Belinda Jakiel, a program coordinator at Whitelion Inc., to the VicHealth Board of Trustees. She was appointed to the Board in January 2002.

Sports Safety Equipment Program 2002

VicHealth actively promotes participation in sport as a way for Victorians to maintain regular exercise. Unfortunately, it is estimated that over 1 000 000 people suffer sporting injuries in Australia each year, resulting in significant health, economic and social costs to individuals and the community. The Sport Safety Equipment Program aims to redress this situation.

Sponsorship of up to $2 500 is available for the purchase of safety equipment for use in sporting programs under this program.

The deadline for applications under this year's program is **Friday 8 March 2002.**

Guidelines and application brochures can be obtained by calling VicHealth on (03) 9667 1333 or from the VicHealth website at www.vichealth.vic.gov.au. Further assistance or guidance in preparing an application can be obtained by telephoning VicHealth on (03) 9667 1353.

VicHealth Visiting Fellow

VicHealth is delighted to announce that our next Visiting Fellow will be Dr Mark Petticrew, Associate Director, Medical Research Council, Social and Public Health Sciences Unit, University of Glasgow. He will be with us from 8–27 March 2002.

Dr Petticrew's PhD was originally in psychology with specific interests in epidemiology and health services research. He later had postings at the London School of Hygiene and Tropical Medicine and the NHS Centre for Reviews and Disemmination as a systematic reviewer. This led to an interest in evidence based policy making. He is currently funded by the Scottish Executive Department of Health to carry out a program of research which involves secondary reviews of non-health sector interventions (such as housing and transport interventions) as well as several controlled studies of housing improvement. He also has an interest in the potential for health promotion interventions to reduce health inequalities.

Dr Petticrew will participate in an extensive three-week program while with VicHealth, including a joint forum between VicHealth and the Cochrane Collaboration which will discuss evidence-based health promotion and public health which will be held at VicHealth on Tuesday 19 March 2002.

For registration and further enquiries regarding this forum, please refer to the VicHealth website at www.vichealth.vic.gov.au.

VECCI/VicHealth Partnership with Healthy Industry Program

Keep the occasional Wednesday free between now and the end of the year as the VECCI VicHealth Healthy Industry Program continues its series of seminars on issues relating to workplace health. Look up the VECCI website www.vecci.org.au for full details.

Wednesday 6 February
Prevention of workplace injuries—both physical and mental

Wednesday 6 March
Mental health

Wednesday 10 April
Building effective workplace teams

Wednesday 1 May
Business and community partnerships/mentoring

Wednesday 5 June
Managing conflict in the workplace

Wednesday 3 July
Bullying in the workplace

Wednesday 7 August
Work life balance

Wednesday 4 September
Occupational stress—practical strategies for identifying causes and consequences

Wednesday 2 October
Workplace design/ECCO efficiency and environment

Wednesday 13 November
Occupational health and safety in the workplace

Wednesday 4 December
Work performance counselling

Upcoming Conferences

Australian Health Promotion Association 14th Annual Conference

The Australian Health Promotion Association 14th Annual Conference is to be held from 16–19 June 2002 at the Sydney Convention and Exhibition Centre, Darling Harbour. The conference theme is 'Made in the Future', a conference on leadership, capacity building, evidence and advocacy.

Further details can be found on the Australian Health Promotion Association website at www.ahpa.org.au.

XVIIIth World Conference on Health Promotion and Health Education

Preparations are underway for the World Conference on Health Promotion and Health Education in 2004.

Some of the preliminary themes identified already are:

- valuing diversity: reshaping power;
- maintaining diversity in a global culture;
- shifting the balance of power: new forms of governance and participation;
- vision, purpose and leadership: exploring different pathways to health by:
  - setting an agenda for promoting Indigenous health;
  - addressing stress from civil unrest, unemployment and cultural change; and
  - restoring the balance between environment, health and spirituality.

One of the significant contributions the IUHPE (International Union on Health Promotion and Education) can make is to invite people to find solutions and act to put them into practice. The XVIIIth World Conference on Health Promotion and Health Education will provide an important platform for this. Conference delegates will be challenged to identify ways in which we can make a difference, personally and collectively. A series of pre-conference workshops and discussion rounds is planned to develop the themes and networks and to take them forward.

For further information, contact Rob Moodie, IUHPE Vice President for the Organisation of the World Conference, at rmoodie@vichealth.vic.gov.au; Marilyn Wise, IUHPE Regional Vice President for the Southwest Pacific, at marilynw@health.usyd.edu.au; or Marie-Claude Lamarre, IUHPE Executive Director, at iuhpemcl@worldnet.fr.

Cochrane Health Promotion and Public Health Field

This year the Field will again offer bursaries to support the production of systematic reviews for publication in the Cochrane Library. The Field is also in the process of producing resources to guide the development of Cochrane reviews of health promotion interventions. On 19 March 2002, the Cochrane Health Promotion and Public Health Field, in collaboration with VicHealth, will be hosting an interactive seminar on evidence in health promotion. A training session on systematic reviews for health promotion initiatives will also be run in May. More details to follow at www.vichealth.vic.gov.au/cochrane.

Publications

The Essential U & I, Yoland Wadsworth and Merinda Epstein (editors) published by VicHealth, 2001.

The Essential U & I is a presentation of the findings of a lengthy grounded study of whole systems change towards staff-consumer collaboration for enhancing mental health services.

For eight years between 1989 and 1996, a remarkable action research study unfolded under the auspice of Victoria's peak consumer mental health organisation—VMIAC.

Part reader and part commentary, *The Essential U & I* presents to an Australian and international audience for the first time some of the key elements of this sequence of consumer research studies that made, and continue to make, a contribution to profound changes in local, state and national mental health services and policy.

This publication is an essential resource for:

- those involved in training and educating mental health professionals;
- staff and consumers currently working to improve mental health services, and
- those interested in the study of whole systems change and participatory action research methodologies.

The Essential U & I is available from VicHealth for $27.50 plus postage and handling.

To order, contact:
Kim Hutchinson
PO Box 154
Carlton South VIC 3053
Phone: (03) 9667 1333
Fax: (03) 9667 1375
Email: khutchinson@vichealth.vic.gov.au

The order form is also available for downloading on the VicHealth website at www.vichealth.vic.gov.au.

Men's Health Promotion: Developing an Intersectoral Strategic Framework, *Rick Hayes*

This Issues Series published by VicHealth in 2001 is available free for all people working in the area of Men's Health Promotion. The first print run has been snapped up and the text is now available in the publications section of the VicHealth website at **www.vichealth.vic.gov.au**.

Mental Health Promotion and Young People: Concepts and Practice, Louise Rowling, Graham Martin and Lyn Walker (editors)

The book draws on the knowledge and experience of 35 of Australia's leading professionals working in the area of mental health promotion. The reference explains concepts and practice for mental health promotion and draws from studies of youth projects and how concepts worked. Published by McGraw-Hill Australia Pty Ltd in 2001 it is available now.

For more information, contact:
McGraw-Hill Australia Pty Ltd
4 Barcoo Street
Roseville NSW 2069
Phone: (02) 9415 9888
Fax: (02) 9417 7003
Email: cservice_sydney@mcgraw-hill.com

VicHealth Website

VicHealth's website www.vichealth.vic.gov.au was revamped in 2001. It contains a wealth of information on health promotion issues, events and programs in which VicHealth invests. VicHealth is continually looking to be innovative and to find new ways of sharing information. Expect a new-look home page in early March and the opportunity for individuals to register to receive regular updates from VicHealth.

The *VicHealth Letter* is produced by the **Victorian Health Promotion Foundation** PO Box 154 Carlton South Vic 3053
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