Editorial

**Fair Foundations for health equity**

**INTRODUCTION**

There is increasing concern with the growing inequities in health experienced by different population groups as result of social processes (Commission on Social Determinants of Health [CSDH], 2008). Evidence shows that those with greater (economic and social) resources are more likely to have better health outcomes than those with lesser resources. This creates a social gradient in health across the population. In the debate on this phenomenon different concepts are used, and it is useful to distinguish between inequality and inequity. Whilst health inequalities include differences in health outcomes that include those caused by natural biological variation, health inequities are health differences that are socially produced. Health inequities are therefore considered unfair and avoidable (Whitehead and Dahlgren, 2006).

In 2005, The World Health Organisation (WHO) reiterated the urgent need to address the social causes of poor health and health inequities and established the Commission on Social Determinants of Health to provide guidance on how to tackle health inequities globally, thereby demonstrating their commitment to an approach that explicitly takes into account a social model of health (CSDH, 2008).

The descriptive literature explaining the social determinants of inequities, and the subsequent economic and social costs, has been widely published; however, fewer resources are available at a practical level to guide policy and programme design. This can be attributed, in part, to the complexities of understanding the different causal pathways leading to inequities in health (Marmot et al., 2008; Diez Roux, 2011), the magnitude of existing health inequities (Friel and Marmot, 2011), the political nature of solutions (Scott-Samuel and Smith, 2015) and a lack of programme and policy evaluations that capture and report on the differential impact of investments (Asada et al., 2014). Addressing inequities requires a deep understanding of the root causes or structural influences that lead to disadvantage and ill-health (Marmot, 2010), and solutions that address these causes require significant changes to governance, policy and social and cultural norms (Whitehead and Dahlgren, 2006; Scott-Samuel and Smith, 2015).

The Victorian Health Promotion Foundation (VicHealth) was established by the State Parliament of Victoria in 1987 and was the world’s first health promotion foundation (VicHealth, 2013b). VicHealth invests in public health research, interventions and campaigns to promote good health and prevent chronic disease. VicHealth is committed to promoting health equity and has endeavoured to address some of the practical challenges in health promotion by producing tools and resources to inform equity focused policy and programme design. In this regard, VicHealth released Fair Foundations: the VicHealth framework for health equity in 2013 (VicHealth, 2013a). The framework is a planning tool designed to inform health promotion programmes and policies that focus on promoting health equity.

The framework was developed in consultation with policymakers and practitioners from the health promotion workforce in Victoria to ensure its applicability and relevance to practice. Fair Foundations draws on the conceptual framework for action, developed and released in 2010 by the WHO’s Commission on the Social Determinants of Health (Roche et al., 2015).

After releasing the Fair Foundations framework, VicHealth commissioned eight rapid evidence reviews to investigate best and promising policy and practice to reduce health inequities within healthy eating, tobacco, physical activity, alcohol, mental well-being, settings for health promotion, early childhood development and social innovation investments. Each article in this supplement draws on the findings from one of the rapid reviews, focusing particularly on discussing the strengths and nature of the evidence base, highlighting research gaps and identifying future research and evaluation priorities. Shorter synthesis versions of the
evidence reviews will be available on the VicHealth website at www.vichealth.vic.gov.au in September 2015.

THE FRAMEWORK

Fair Foundations is both a conceptual and action oriented framework for addressing inequities and can be applied to any public health issue. Fair Foundations outlines three layers of the social determinants of health inequities. The three layers are referred to as the layers of influence. The three layers of influence are the socioeconomic, political and cultural context; daily living conditions and individual health-related factors. These layers are presented visually within the root system of a tree. Public health action can be taken at any of the three levels of the framework with entry points for action and prompts for
planning provided at each layer. For this level of detail, view the full version of framework on the VicHealth website (https://www.vichealth.vic.gov.au/media-and-resources/publications/the-vichealth-framework-for-health-equity).

The socioeconomic, political and cultural context is represented at the base layer of the framework, where the root of the tree is deepest. The socioeconomic, political and cultural context includes governance, macro-economic and social policies and the dominant cultural and societal norms and values in a society. These factors exert a deep and powerful influence on health through their impact on social stratification and people’s daily living conditions (Wilkinson and Pickett, 2009; Roche et al., 2015).

Daily living conditions are represented within the middle layer of the framework. Daily living conditions comprise the circumstances in which people are born, live, work and age. The quality of these conditions affects people’s material circumstances, psychosocial control and social connection, and can therefore be protective or damaging to health. The daily living conditions considered in Fair Foundations include early child development, education, work and employment, the physical environment, social participation and healthcare services.

The top layer of influence represents individual health-related factors such as health-related knowledge, attitudes and behaviours. Positive changes in health-related knowledge, attitudes and behaviours are often most easily achieved among people who have sufficient power, money and resources (Roche et al., 2015). This layer of influence is located at the top of the root system of the tree, just below the surface of the soil.

The root system then emerges into a tree, epitomizing the health and well-being outcomes and their social distribution that are observed within a society. The framework demonstrates how deep-rooted socially produced factors contribute to the differences in health and well-being outcomes experienced by different groups within a population.

A settings-based, a social innovation and a life course approach looking at early childhood development were also investigated as these are common approaches used to inform the design of public health investments (Darnton-Hill et al., 2004; Gardner et al., 2007; Dooris, 2009). The rapid reviews used the Fair Foundations framework as a structure to investigate and guide the evidence reviews and analysis of evidence.

Roche and colleagues outline the existing inequities in alcohol consumption and related harms acknowledging the complexities that exist because of the differences in patterns of drinking behaviours and patterns of harms experienced within social groups (Roche et al., 2015). Consumption behaviours and alcohol-related harms are often not associated, making it difficult to identify patterns and relationships within different social groups. The authors outline the social determinants that most strongly influence alcohol consumption patterns and related harms and identify interventions that have shown the greatest potential for decreasing inequities in contrast to those likely to exacerbate health inequalities.

Successful physical activity interventions addressing inequities are investigated by Ball and colleagues (Ball et al., 2015). Physical activity was considered in relation to leisure time and transport-related physical activity as well as sedentary behaviour. The evidence of a disaggregated effect of sedentary behaviour on health inequities was particularly limited as this is currently an emerging field; however, a number of physical activity interventions that show promise across all population groups at each level of the framework are identified and discussed in relation to their implications for addressing inequities.

Walsh and colleagues focus on promoting the mental well-being of children as childhood is a critical life stage whereby children develop mental health capital (Walsh et al., 2015). Walsh highlights that the existing evidence base primarily focuses on mental illness in childhood or the social determinants of physical health, with limited evidence for the promotion of mental well-being in childhood or an analysis of the social determinants of mental well-being outcomes (Walsh et al., 2015). The interventions...
showing the most promise for improving childhood mental well-being and reducing inequities therein were those delivered in family or education settings, and best practice examples are provided with a discussion of the key factors likely to contribute to an interventions success.

Friel and colleagues apply the framework to equity in healthy eating, identifying several factors within the food system such as agricultural production, trade, manufacturing, retail, food services and advertising as determinants effecting the availability and cost of different foods (Friel et al., 2015). The deeply engrained norms, values and traditions that different population groups have in relation to eating, food preparation and nutrition are explored as they are important social determinants to consider when developing equitable healthy eating interventions.

Newman and colleagues investigate opportunities to address health inequities taking a settings approach to health promotion, investigating the evidence within 12 prominent settings for health promotion including cities, communities and neighbourhoods, educational, healthcare, online, faith-based, sports, workplaces, prisons, nightlife, green and other temporary settings (Newman et al., 2015). The authors emphasize the need for settings-based approaches to focus on changing the structures within a particular setting, providing examples of this approach, and outlining how individual behaviour change approaches implemented in isolation can further exacerbate inequities.

Moore and colleagues investigate early childhood development taking a life course approach to addressing inequities (Moore et al., 2015). Similar to Walsh’s research, early childhood was the focus because this an important developmental life stage whereby life-long health behaviours are developed. Moore discusses how the critical pre-natal and post-natal periods can impact on healthy development and health outcomes later in life, and how inequities are created and can be addressed in the early years.

The final review lead by Mason et al. focuses on social innovation and the opportunities it provides for reducing inequities in health (Mason et al., 2015). Innovation is central to VicHealth’s model as an approach to drive new ways of addressing health priorities. In this review, social innovation is defined as ‘a novel solution to a social problem that is more effective, efficient, sustainable, or just than existing solutions and for which the value created accrues primarily to society as a whole rather than private individuals’ ([Phills et al., 2008], p.38). Four key areas of social innovation for health equity promotion were investigated including social movements, service-related social innovation, digital social innovation and social enterprise.

**LIMITATIONS**

The evidence reviews, which informed the articles in this special supplement, were rapid evidence reviews conducted over an 8–12-week period. Rapid reviews were conducted because practical and timely recommendations were required to support the operationalization of VicHealth’s Action Agenda for Health Promotion 2013–2020. In contrast, a traditional systematic literature review is more resource intensive, taking between 6 and 12 months to complete (Gannan et al., 2010). Systematic reviews therefore have a more rigorous process, which is less susceptible to sampling and reporting biases, generating more robust findings than can be achieved through a rapid review (Tricco et al., 2011). Rapid reviews can maintain their validity if the principles and methods of a systematic review are adhered to (Tricco et al., 2011). The authors have endeavoured to uphold the key principles by outlining their search strategy and the methods and criteria used to identify the evidence that is presented, providing transparency of their review process and highlighting the limitations of a more streamlined approach.

While the case examples included in the articles are predominantly Australian, we believe the principles and approaches within them are relevant to other high income countries. The systematic causes of health inequities are of a similar nature internationally and the economic and political context within OECD countries, particularly Australia, the USA, New Zealand, Canada and the UK create similar challenges for addressing inequities.

**KEY THEMES**

The authors of this Supplement’s contributions consistently report that there is limited literature investigating public health interventions that explicitly aim to address health inequities, as well as very few programme evaluations that adequately measure and report on the differential and adverse impacts of a programme or policy across different social groups. The authors emphasize that it is particularly necessary to understand the long-term impacts of interventions for different population groups to be able to determine their ability to reduce inequities as short-term impacts are often not sustained beyond the life of an investment.

These findings are consistent with other international research findings (Lorenc and Oliver, 2014; Bonell et al., 2015). In a systematic review on the types of interventions that are most likely to generate inequities, Lorenc et al. (Lorenc et al., 2012) concluded that public health programme evaluations do not adequately report on unintended consequences so there is inconclusive evidence
for best practice (Lorenc et al., 2012). More recently evaluation frameworks have been proposed to address this evidence gap and bring consistency and rigour to the reporting of programme outcomes, the frameworks emphasize the necessity to investigate and report on unintended harms, specifically intervention-generated inequalities (Lorenc and Oliver, 2014; Bonell et al., 2015). The lack of evidence in most cases restricted the author’s recommendations to a discussion of interventions that were only likely to reduce inequities and of those that had showed promise.

Interventions categorized at the top layer of the framework due to their focus on individual behaviour change were the most common types of investments identified in the literature. The authors commonly found little or no evidence demonstrating the equity impact of these interventions in the long term, unless these efforts were accompanied with broader structural changes within the middle or base layer of the framework.

Interventions at the base layer of the framework, focusing on the socioeconomic, political and cultural context of a society, were recognized as those likely to have the greatest impact on reducing inequities, however the authors commonly recognized that interventions at this level are the most challenging to implement and evaluate considering their broad, long term and often political nature.

The Nutbeam Review of a national research funding scheme in Australia acknowledged the tendency for funding systems to encourage descriptive research over practical research on policy and practice, as well as an overall lack of coordination by national funding bodies to facilitate cross-sector collaborative research efforts and knowledge sharing (National Health and Medical Research Centre [NHMRC], 2008). Katikireddi et al. recommend that funding bodies prioritize collaborative research between health and non-health sectors and encourage the exploration of broad societal level influences on health and health inequalities to shift the current narrow focus of health research (Katikireddi et al., 2013). De Leeuw et al. recommend that political science research be prioritized by national funding bodies to encourage research that will provide a better understanding of how to influence and evaluate policy (De Leeuw et al., 2014).

The Australian-generated evidence suggests that it is of critical importance to understand the views and experiences of Aboriginal and Torres Strait Islanders, people from culturally and linguistically diverse backgrounds, refugees, migrants, and of those experiencing homelessness or living in rural and regional settings. Consulting with the most vulnerable groups in a community and providing them the opportunity to meaningfully contribute to the programmes and policies that affect them are central to achieving greater equity (Scott-Samuel and Smith, 2015).

Consistently across the papers a multi-sectoral, universal approach that incorporates targeted strategies allocated in relation to need was recommended, with the necessity to undertake evaluations that measure and report on the long-term differential impact of the intervention.

CONCLUSION

The evidence reviews are supporting VicHealth with practical application of the Fair Foundations framework to practice for the integration of health equity principles into programmes and policies. Evidence remains limited, however the authors highlight promising practice and demonstrate the importance of focusing on upstream investments that investigate and address the broader determinants of ill-health. The evidence base effectively describes inequities as a social problem, however there is limited literature guiding the development of policies and programmes that will benefit the most vulnerable groups within our society. This is due in a large part to the fact that the evidence provides guidance on how to consider health equity in public health investments within the current social, political and economic context.

Understanding the current evidence base is critical to this work, but perhaps even more important is imagining and exploring alternative future scenarios which consider the types of societies and institutions that might enable more equitable health (Scott-Samuel and Smith, 2015). Publication of the articles in this supplement endeavours to encourage discussion, debate and research within a solution-focused paradigm that brings health equity to the forefront of the social agenda.

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REFERENCES


