

People & Place

Developing a Research Program for Understanding and
Addressing Place-based Health Inequities in Tasmania

Brendan Churchill
Theresa Doherty
Emily Hansen
Richard Eccleston



Contents

| | |
|--|-----------|
| Introduction..... | 3 |
| The Tasmanian Context..... | 3 |
| Understanding and Defining Inequity..... | 5 |
| The Determinants of Health | 7 |
| Social Determinants of Health | 8 |
| Social Gradient..... | 8 |
| Social Capital..... | 9 |
| Social Exclusion | 9 |
| Policy Responses to Health Inequities | 10 |
| Social and Community Inclusion..... | 12 |
| Place Based Approaches..... | 13 |
| Compositional Explanations of Place-based Health Inequalities..... | 14 |
| Contextual Explanations of Place-based Health Inequalities | 15 |
| Re-conceptualising Place | 17 |
| Lay Knowledge and Place | 20 |
| Implementing Place Based Policy | 22 |
| Governance for Place Based Interventions..... | 29 |
| Characteristics of Successful Place Based Interventions | 30 |
| Critiques of Place Based Approaches..... | 31 |
| Summary of What We Know and What This Means | 31 |
| Knowledge Gaps | 32 |
| Governance models for place based initiative | 32 |
| Understanding the social mechanisms of causation | 33 |
| Extending concepts of place | 33 |
| Synergetic effects of multiple risk factors | 33 |
| Social exclusion | 33 |
| Agency..... | 34 |
| Impacts of areas based initiatives..... | 34 |
| Transferability | 35 |
| Future Research Directions..... | 36 |
| References..... | 38 |

Introduction

In middle and higher income countries, population health outcomes have improved dramatically since the mid twentieth century as measured by key indicators such as life expectancy and mortality rates from disease. Large scale public health initiatives such as vaccination and population based health screening have played their part as have health services from primary care through to tertiary treatments. As well, health promotion initiatives have targeted major risk factors including smoking, unsafe sex, physical inactivity and drug and alcohol misuse, with some significant reductions in risk behaviour amongst populations. Baum (2007) cites the success of health promotion initiatives to reduce smoking prevalence, road accident fatalities, and suicide rates and skin cancer incidence in Australia.

Despite the advances, these health goods are not equitably dispersed throughout the population. Health status and health outcomes are characterised by a social gradient whereby the most advantaged members of the population enjoy the best health outcomes whilst the most disadvantaged have the worst (Macintyre 2007). So while there have been steady improvements in life expectancy, health outcomes and health related behaviours across whole populations, these overall gains have concealed a widening gap between the most advantaged and the least advantaged (Klein 2004, Baum 2007, Dahlgren & Whitehead 2006, Macintyre 2007) resulting in entrenched—and worsening—heath inequities.

Health inequities can be defined as group or population-level health outcome differences that could have been avoided under fairer circumstances (DHHS 2011). Tackling health inequities is difficult without addressing social inequalities¹. Health inequities, grounded in the social determinants of health (SDH), take on the characteristics of ‘wicked problems’, that is, they cross sectoral boundaries and are resistant to solutions available through the action of a single agency. Wicked problems resist clear definition, feature a great number of elements connected in a non-linear fashion and involve many stakeholders (Bradford 2005). As such they require a sophisticated and nuanced policy response. Place-based approaches, which have been adopted nationally and internationally, are one such response. However, their efficacy remains contested and the ways in which ‘place’ mediates health outcomes are not yet fully understood.

This report examines current understandings of place based policy interventions and their capacity to ameliorate health inequities. It considers constructions of place and the relationships between disadvantaged populations, place and health inequities, as well as potential policy interventions. Further, it identifies a potential research agenda to enhance our understandings of place based policy approaches and their potential for addressing health inequities in Tasmania.

The Tasmanian Context

Health inequity is a particular concern for Tasmania, which falls behind the nation on many important measures of health and health related behaviours. The Tasmanian population experiences greater levels of disease and disability overall and particular groups within the population are more vulnerable to poor health outcomes.

¹ Dr Rudiger Krech, Director of Department of Ethics, Equity, Trade and Human Rights & Head of Conference Secretariat, World Conference on Social Determinants of Health, Brazil 2011.

Tasmania has the highest percentage of households in the nation who are dependent on government pensions and allowances. Over 64,000 Tasmanians or 13 per cent of the population live on or below the poverty line; the resultant social and economic disadvantage puts them at a significant risk of poor health. Further, as shown in Table 1, a considerable number of Tasmanians experience risk factors for social exclusion, which is also implicated in poor health outcomes (DHHS 2011).

Table 1. Numbers of Tasmanians with Selected Risk Factors for Social Exclusion

| Risk Factor | Number (rounded) | Reference Year |
|---|-------------------------|-----------------------|
| <i>Exclusion from housing</i> | | |
| People who are homeless | 2,500 | 2006 |
| People waiting for public housing | 3,000 | 2009 |
| <i>Exclusion from jobs and skills</i> | | |
| Adults with poor literacy skills (aged 15-74) | 174,000 | 2006 |
| Adults (aged 25-64) with no qualifications | 116,000 | 2008 |
| Long term unemployed (aged 15 and over) | 2,200 | 2008-09 |
| People employed part-time | 75,000 | 2008-09 |
| Children living in jobless families | 21,000 | 2006 |

Compared with the national average, they are more likely to be overweight or smoke and, while physical inactivity is comparable to Australian rates, it is still unacceptably high. Table 2 provides a comparison of selected risk factors for chronic disease in the Tasmanian population compared to the national average.

Table 2. Selected chronic disease risk factor prevalence (% adults aged 18+)

| Risk Factor | Indicator | Tasmania | National Average |
|---------------------|---|-----------------|-------------------------|
| Smoking | Current daily/occasional smokers | 24.9 | 20.8 |
| Alcohol misuse | At risk of long-term alcohol-related harm | 13.6 | 13.4 |
| Physical inactivity | Classified as sedentary | 72.1 | 72.3 |
| Overweight | Overweight/Obesity Body Mass Index | 64.0 | 61.2 |

(Source: National Health Survey Data 2007/08)

Tasmania's higher burden of disease from chronic conditions and poor risk factor profile is demonstrably linked to its higher proportion of lower socioeconomic populations. Much higher levels of poor and fair health (36.6%) are reported by Tasmanians on lower income levels than by those in the highest household income levels (6.7%). Table 3 shows the distribution of selected risk factors for chronic disease across Tasmania's social gradient, with those on lower incomes more likely to be physically inactive or to smoke. Risky alcohol consumption levels are the exception to this pattern, remaining stable across the lower income quintiles and increasing to the highest income group.

Table 3. Selected chronic disease risk factor prevalence by household income

| Risk Factor | % within household income quintile | | | | |
|--|---------------------------------------|-----------------|-----------------|-----------------|--|
| | 1 st (Lowest Income) | 2 nd | 3 rd | 4 th | 5 th (highest income) |
| Daily/occasional smoking (persons aged 18+ years) | 32.1 | 29.4 | 24.9 | 23.9 | 15.6 |
| Alcohol consumption levels at risky/high risk for long term harm | 9.4 | 9.6 | 9.9 | 15.6 | 17.0 |
| Sedentary activity levels (persons aged 12+ years) | 41.9 | 41.9 | 33.8 | 27.4 | 17.8 |

(Source: National Health Survey Data 2004/05)

The pattern of disadvantage in Tasmania means that certain communities are more at risk of poor health than others. In 2006, 38,600 people or 8% of the population were living in communities ranked among the most disadvantaged in Australia. The raw data which is available suggests that disadvantage is concentrated spatially, with 43% of the State's disadvantaged found in just four of the 29 Local Government Areas in 2007 (DHHS 2011).² With such a high level of risk, the need to develop and implement policies to address inequity are crucial if individuals and communities are to maximise health and wellbeing and access social goods in a fair and just manner. Beyond such equity considerations, high levels of health inequality also add to the financial burden on State governments in the Australian context because citizens from lower socioeconomic background rely heavily on the public provision of health services.

Understanding and Defining Inequity

Understanding and reducing health inequities remain central challenges for public policy. Three factors place vulnerable populations at increased risk of poor health outcomes. First, the quality of the environment in utero and in early childhood impacts profoundly on health throughout the lifecourse. Secondly, disadvantage throughout life makes people more susceptible to the lifestyle risk factors associated with poor health. Smoking, poor nutrition, physical inactivity and psychosocial distress are all linked to socioeconomic status. Finally, disadvantage reduces access to services and resources during times of poor health. Access to transport, type of employment, health literacy, and level of education are all linked to ability to access effective health and social care. Ameliorating health inequities requires interventions at a number of levels: social and economic conditions, behaviours and access to services (DHHS 2011).

Explanatory models highlight the multifactorial character of the pathways leading to health inequities and are strongly social in orientation. They point to the enduring and unequal risks to health arising from injustices in the way societies are organised, and which impact differentially on

² It must be acknowledged that Tasmania's population is heavily concentrated in the larger metropolitan LGAs. A central conclusion from this report is that more detailed research is required to establish the spatial distribution of health inequality and the role of 'place' in this relationship.

particular groups living in particular places (Mathieson *et al.* 2008). The social determinants of health are the structural (political, economic, and social) drivers and norms which distribute the power, income, goods, and services which shape the conditions of daily living (Friel *et al.* 2001).

Mathieson *et al.* (2008, 67) argue that the:

...fundamental driving force for social inequalities and thus for health inequalities (is) power embedded in social relationships and exercised through formal and informal institutions and organisations making up the socioeconomic and political contexts in societies.

A number of theories have been developed to explain why socioeconomically disadvantaged groups tend to have poorer health (Baum 2008, DHSS 1980, NHS 1992, Marmot & Wilkinson 2006). The three most widely used are cultural and behavioural explanations, material/structural explanations and psycho-social explanations. However the causes of health inequality are complex and most likely involve interaction between different factors.

Cultural and behavioural explanations are based on the assumption that patterns of health are at least partially correlated with the different life styles, practices and behaviours of individuals, viewed as choices. This thinking underpins traditional health education and health promotion programs where the focus is on changing individual risk behaviours through education (for example smoking, alcohol and drug consumption, physical inactivity or poor nutrition). These explanations are attractive because they offer a sense that individuals can control their own health and contemporary western culture places considerable emphasis on individual responsibility for health. However, they have been criticized for victim blaming and for neglecting the broader social context of behaviours (Hansen and Easthope 2007). They have also been largely ineffective for informing policy interventions in terms of reducing population health inequities; in fact some such interventions have actually increased inequities. For example smoking prevalence amongst poorer people in Tasmania continues to increase while the overall population smoking prevalence declines (DHHS 2009).

Materialist or structuralist explanations place greater emphasis on how life chances are shaped by an individual's social location (and thus social structure) with subsequent impacts on health. Life chances, for example, include social opportunities, material advantage/disadvantage, living conditions, working conditions and access to education and social support (Macintyre 1997). Materialist explanations also place a greater emphasis on relative access to the physical resources needed for good health including safe food, water, air and housing. Such access is shaped by social factors, in particular the power of different groups to control physical resources. More recently, this category of explanation has expanded to include an interest in the role of 'place' in shaping patterns of health and illness. Any analysis of the causes of health inequality clearly needs to provide careful consideration of the impact of structure factors on patterns of wellbeing. However it is also important to note that sub-national governments in particular have limited capacity to address deeply entrenched socioeconomic inequality and consequently policy efforts should focus on the dimensions of inequality most amenable to change. A more recent development is explaining health inequality using psycho-social factors. These include some social capital explanations and some of the work on social exclusion. Psycho-social explanations have developed in response to two features of health inequality in advanced western societies. The first is how health inequalities continue even in societies in which all members have access to the material resources required for health (thus the shift from absolute to relative poverty). The second is the social gradient of health inequality, as revealed by the Whitehall studies, whereby health is poorer for each step down the social scale, as measured by occupational groupings.

Comment [UTAS1]: Feel free to delete this sentence if you think its going to open a can or worms!

The Determinants of Health

The Dahlgren/Whitehead (1991) model conceptualises the determinants of population health as 'rainbow-like layers of influence'. At the centre of the model are individuals with their unique biological and genetic inheritance. Behaviours and lifestyles are embedded in social norms and networks, shaped by living and working conditions which are constructed by socioeconomic, cultural and environmental factors. The processes operating within each domain, and across domains, contribute in complex ways to the genesis of health inequalities (Mathieson 2008).

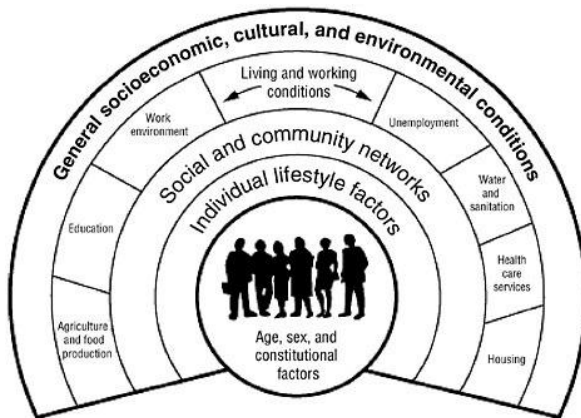


Figure 1. Dahlgren and Whitehead Model 1991

Dahlgren and Whitehead (2006) point to the importance of recognising a key conceptual difference: between the determinants of *overall population health* and the determinants of *social inequities in health*. This is particularly important for policy design as interventions which tackle the former may do little to reduce the health divide.

- **Determinants of health** are the factors that influence health positively or negatively. These are the social, economic and lifestyle-related determinants of health that can be influenced by political, commercial and individual decisions and are separate from individual factors such as age, sex and genetic endowment.
- **Social inequities in health** are systematic differences in health status between socioeconomic groups, as measured by income, education and occupation. These inequities are socially produced and thus modifiable. If the social and environmental circumstances of people's lives are critical to shaping their health behaviours and health outcomes, then interventions at a structural level that impact on social inequities should impact on health inequities.
- **Determinants of social inequities in health** are those social, economic and lifestyle-related factors that increase or decrease social inequities in health and can be influenced by political, commercial and individual choices/decisions.

Wood *et al.* (2005, 3) distinguish between policies which focus on:

... improving the health of disadvantaged groups (tackling health disadvantage), reducing health differences between disadvantaged groups and other groups (tackling health gaps), and reducing the gradient in health outcomes across all groups in the population, from the most advantaged to the most disadvantaged (tackling health gradients).

Social Determinants of Health

The social determinants of health are those conditions of daily living that determine a person's chances of achieving good health: the conditions in which people are born, grow, live, work and age. Also known as the causes of the causes, they include: a safe environment, adequate income, meaningful roles in society, secure housing, higher levels of education, and social support within communities, all of which are associated with better health and wellbeing. The social determinants of health play a greater role in determining health than has been found for access to health care services (DHHS 2011).

Dahlgren and Whitehead (2006) say it is critical to distinguish between the social determinants of health for the whole population and the social determinants of inequities in health because the most important determinants of health may vary for different socioeconomic groups. One's social position in a society and the distribution of power and resources in that society exert a powerful influence on the type, magnitude and distribution of health risks experienced. Those who enjoy higher socioeconomic status (SES) typically have more power and opportunities to live a healthy life than those with lower SES. Policies which aim to reduce difference in income or education are likely to have a positive impact from a health equity perspective.

Social Gradient

The social and economic status of all individuals and communities within a society can be measured and represented as a gradient. The relationship between position on the gradient and health indicates that potentially the health of everyone—even the already well off—can be lifted to match the people at the very top of the social gradient (DHHS 2011).

Marmot *et al.* (1978) found that risk factors played only a small role in explaining the social gradient and in later work (Marmot *et al.* 1991, Marmot 2004) discovered the relationship between social position in an organisation, perceived level of control and psycho social wellbeing. Thus it is not only the most disadvantaged who have the worst health, but the social gradient demonstrates that for every step up the social scale (or higher on the gradient) there is a concomitant improvement in health (Marmot *et al.* 1978). The work of Marmot and his collaborator Wilkinson (1996) draws attention to the issue of relative inequality and the possible role of status, stress, lack of control and perceptions of difference in creating health inequalities. The literature on place-based approaches described below suggest that community-driven responses may be able to address these sources of relative inequality.

Social position is in itself an important determinant of social inequities in health. It has an important psychosocial dimension which in turn determines whether people feel valued and needed as opposed to insignificant and stigmatized. Wilkinson (1996 cited in Mathieson 2008) argues that the most important pathways between health and income inequalities are psychosocial. Davidson *et al.* (2006) found that people at the bottom of the social hierarchy have to bear the direct consequences of their poverty alongside living in a society which also makes them acutely aware of the goods and

privileges they lack. The expressed feelings of being 'marked', of feeling shame, anger, frustration, rejection, injustice and alienation all impacted negatively on their health.

Social Capital

Social capital '...has been widely theorised as a mediating link between socioeconomic inequality and health' (Mathieson *et al.* 2008, 33). However, there are a number of different understandings of the concept of social capital in the literature. Putnam (cited in Mathieson 2008) sees social capital as the social infrastructure ('wires') that enable individuals to gain access to resources. While it is a property of individuals, social capital is only realised through group/community membership. Alternatively, social capital can be understood as the resources that flow through networks; 'the electricity rather than the wires' (Mathieson *et al.* 2008, 34). Bourdieu defines social capital in terms of networks, but emphasises their role in the constitution and maintenance of hierarchical class relations and social and economic inequalities³ (cited in Mathieson *et al.* 2008).

Baum (2007 PAGE NUMBER) uses the concept 'linking social capital', defined as '...the norms of respect and networks of trusting relationships between people who are interacting across explicit formal or institutionalised power or authority gradients in society'. Linking social capital is seen as one of the processes that can ensure that social and health policy are underpinned by the principles of fairness and justice. For Baum (2007 PAGE NUMBER) '...action on health equity requires a complex mix of sufficient evidence, understanding of what changes population health, a political elite committed change and an active civil society'.

A society high in linking social capital is likely to be characterised by:

- High trust in formal institutions
- Fair and transparent public policy processes
- Commitment to redistribution of resources
- Commitment to activities of state
- opportunities for different groups to interact in a respectful manner (Baum 2007).

Baum (2004) posits that linking social capital suggests a policy approach which provides communities with the infrastructure to create a health promoting environment. This form of social capital ensures that the more advantaged members of a society are prepared to support initiatives which reduce inequities as a means of improving health (Baum 2007).

Social Exclusion

Social exclusion had been proposed as an important concept in understanding health inequalities. The concept is contested, and has multiple meanings which Matheson *et al.* (2008) claim are '...continually redefined over time and have different policy implications'. Social exclusion is understood variously as a state of multiple disadvantage, a lack of participation in society, a lack of citizenship rights for members of particular groups or communities, or as the processes embedded in unequal power relationships that create inequalities. Despite these multiple meanings, there is some consensus in the literature that 'social exclusion' operates at different social levels, is dynamic and

³ This is part of his account of different forms of capital; economic, cultural, social and symbolic and their interrelationships.

has relational, social, political, cultural and economic dimensions which result in a lack of social participation, social protection, social integration and power (Mathieson *et al.* 2008).

A social exclusion lens focuses on the causes of poverty and inequality as well the outcomes, and encourages the exploration of macro-micro linkages. Explicating these linkages is central to understanding social inequalities in health—how and why inequalities are generated and reproduced, rather than focusing on the health outcomes of those inequalities. This brings people's lived experiences, the relationship between agency and wider social structures and the historical context into the analysis (Mathieson *et al.* 2008).

Central to the concept of social exclusion is the abuse of power which restricts participation in economic, social, political and cultural relationships with resultant negative impacts on health and wellbeing. Mathieson *et al.* (2008, 64) claim that:

An instrumental perspective would locate social exclusion firmly within the relational domain: referring to and encompassing the economic, political, ideological, social and cultural processes that generate differential 'terms and conditions' of inclusion and/or exclusion. These result in deprivations such as low income, poor nutrition, housing problems, etc., which contribute to ill-health. Alternatively, seen as a 'constituent' element of deprivation (rather than a driver of it) having the right and freedom to participate fully in economic, social, political and cultural relationships has intrinsic value and the experience of restricted participation can be expected to increase exposure and/or vulnerability to negative health outcomes. Moreover, poor health and disability can themselves generate exclusionary processes—by limiting people's ability to find and retain paid work for example, or through the stigma often associated with ill-health further restricting social participation.

Exposure to health hazards is inversely related to social position. There is some limited research which points to a multiplier effect amongst the socially disadvantaged, perhaps due to exposure to several risk factors⁴ simultaneously which reinforce health inequities. In order for the cycle of poor health to be broken, these clusters of risk factors with synergistic effects imply the need for public policies which provide for multiple entry points and interventions (Dahlgren and Whitehead 2006).

Policy Responses to Health Inequities

There are a number of different possible policy approaches for tackling health inequalities. The policy focus can be on improving the health status of the worst off groups only, on narrowing the gap between those in worst health and those who are of average health, or on reducing the overall gradient in health experiences across society. Mathieson *et al.* (2008) say that policies aiming to address health inequalities typically take the first two approaches—rather than tackling the overall gradient—focusing energy on the worst off who are often the most socially excluded and difficult to reach.

Mathieson *et al.* (2008) argue that while targeted policies have a role in creating more equitable societies, a sole focus on the poorest and/or the gap between them and the rest of society fails to recognise the crucial causal link to inequalities in power across societies and the potential for agency

⁴ Dahlgren and Whitehead suggest the combined effects many factors, such as social exclusion, low income, alcohol abuse and poor access to health services drive health inequities.

amongst the most marginalised groups. In contrast, a focus on relational exclusionary processes forces attention onto the causal role of social and economic inequalities which are driven by unequal power relationships. This approach highlights the need for policies with two parallel and closely linked dimensions to reduce health inequities: action to address the generative processes embedded in social relationships; and emancipatory processes supporting full and genuine participation in identifying and acting on inequalities and the transformation of power relationships' (Mathieson *et al.* 2008). Pickett and Dorling (2010) argue that health inequalities are not simply problems of the poor, so it makes little sense to direct policy initiatives only at the worst off. It makes more sense to reduce the social inequalities that actually produce social disparities in health in the first place; this requires political will and capacity.

Exworthy (2008) notes that the complexity and the life course dimension of tackling health inequalities presents a number of challenges for the conventional policy process:

- Timescale: the outcomes of early interventions may not be evident for many years and almost certainly not with the term of an electoral or administrative reporting cycle. Further, issues do not maintain their salience on the policy agenda, rather they move on and off as interests in any particular issue wax and wane.
- Multi sectoral policy response: traditional vertical organization of government agencies is not well suited to deal with cross cutting issues thus new governance, accountability and partnership models are required to both formulate and implement policy.⁵
- Ownership: organizational partners may not see the issue as core to their own business.
- Competing priorities for policy resources: 'downstream' health *care* is often the policy priority rather than 'upstream' social determinants of health.
- Cause-effect relationships are not readily apparent: attribution of policy interventions may not be easily ascertained given the multi-faceted nature of policy outcomes. Outcomes may not be evident for many years so there is a reliance on process measures as indicators of progress and an (often untested) assumption that in time these will lead to desired outcomes.
- Globalisation: national governments' policy choices can be constrained by international events, e.g., global financial crisis, World Bank ratings.

Macintyre (2007) identifies a number of principles for effective policies to reduce inequalities in health:

- Maintain and extend equity in health and welfare systems.
- Address 'upstream' and 'downstream' causes.
- Level up not down.
- Reduce inequalities in life circumstances (especially education, employment, and income).
- Prioritise early years interventions, and families with children.
- Address both health care and non health care solutions.

⁵ Arguably a coordinated 'new governance' approach is more difficult to implement in a federal system such as Australia's.

- Target, and positively discriminate in favour of, both deprived places and deprived people.
- Remove barriers in access to health and non-health care goods and services.
- Prioritise structural and regulatory policies.
- Recognise the need for more intensive support among more socially disadvantaged groups.
- Monitor the outcome of policies and interventions, both in terms of overall cost effectiveness and differential cost-effectiveness.
- Ensure programmes are suitable for the local context.
- Encourage partnerships, working across agencies, and involvement of local organisations.

Social and Community Inclusion

Klein (2004,113) states that the 'causal nexus between poor health status, socioeconomic inequality, social exclusion and locational disadvantage has a number of policy and practice implications that are rarely taken into consideration in formulating responses to health disparities'. The traditional policy response of making services more accessible is a necessary but insufficient response because health services cannot substantially influence the upstream factors. Shifting the focus from biomedical to behavioural strategies is not the solution either as traditional health promotion strategies have not substantially transformed risk patterns amongst the poor and can have the perverse impact of actually increasing health inequalities (e.g., smoking). Arguably a grounded place-based evaluation of such strategies has the potential to enhance our understanding of this phenomena.

Acheson *et al.* (1998) suggest policy options to promote social and community inclusion include bolstering individual social support, and promoting horizontal and vertical interactions in populations. Providing additional health and social services to disadvantaged groups such as emotional support to parents of young children is an example. Horizontal interactions, between members of the same community or group allow community dynamics to work. This might include place-based strategies such as community development initiatives that enable people to work collectively on their identified priorities for health or creating neighborhood infrastructure that facilitates social interaction.

Vertical social interactions enable the creation of vertical bonds between groups from the top of the social scale to its bottom, to build inclusiveness and full economic and political participation. Fostering solidarity across SES groups results in a less divided society, with smaller social inequities and hence more equitable access to resources for health (Acheson *et al.* 1998). Social welfare and educational systems in which everyone contributes and everyone benefits and initiatives which strengthen the democratic process and make it easier for the disenfranchised to participate (Dahlgren & Whitehead 2007) are initiatives which build vertical inclusion. In line with the focus on inclusion, Dahlgren and Whitehead (2007) further suggest that strategies for reducing social inequities in health should be seen as an integrated part of population-based policies and programmes for health development. Just as the age and gender dimensions of policies are considered, so should the social equity dimension. Such considerations might include

- Identifying specific equity-oriented objectives and targets.

- A realistic assessment of possibilities and constraints including of those actions that generate inequities in health.
- Governance structures for intersectoral collaboration and effect effective implementation across different levels of government.

Place Based Approaches

Orthodox approaches to the reduction of health inequalities and effecting sustainable change have had limited effectiveness. Strategies such as making existing services more accessible and focusing on individual behavioural do not address the root causes. In recent years the concept of the place-based approach which addresses the broader determinants of health has emerged as a new way of looking at health inequity and as a potential solution to entrenched social inequities which underpin health inequities. All people live in places, contribute to places and are affected by places. Poverty and disadvantage are mediated by place, and places are affected by the poverty or otherwise of their inhabitants (ASIB 2010b). Geographers and sociologists have long argued that place is relevant for health variation because it constitutes as well as contains social relations and physical resources (Cummins *et al.* 2007). Researchers in other disciplines are also interested in explicating the influence of place and its physical, social, historical and cultural dimensions in order to gain a more comprehensive understanding of individuals' experiences of health and illness (Cummins, Curtis, Diez-Roux & Macintyre 2007, Macintyre, Ellaway & Cummins 2002, Macintyre & Ellaway 2000).

Place based initiatives to promote health and reduce health inequities gained momentum in the 1980s in the wake of the Ottawa Charter⁶. The nexus between health inequities and socioeconomic status is now well established and there is a growing consensus that 'place' has a significant impact on how inequity is manifested and produced (O'Dwyer *et al.* 2007, McLaren & Hawe 2005). The interest in place-based understandings of health inequalities also reflects the development and increased acceptance of the 'new public health'⁷, which suggests a more comprehensive approach to health and illness incorporating social, environmental and structural factors (Diez-Roux 2007, Frohlich, Corin & Potvin 2001, Macintyre & Ellaway 2000) rather than focusing on the individual. This approach allows for a more nuanced understanding of health inequities as not only socially but also spatially distributed. As such, places are potentially an important intervention point for new public health strategies (Duncan & Brown 2000). Significantly in the Australian context, State Governments have both the jurisdictional authority and the capacity to systematically address many of the causes of health inequality identified in the place-based literature.

Cummins *et al.* (2007) report that recent advances in 'place-based' health research have focused on the articulation and development of plausible conceptual models of the causal pathways by which 'place' (especially place of residence) may influence health. There has also been a growing emphasis on the importance of gathering empirical evidence to substantiate these theories and as a consequence we outline an agenda for further research in the Tasmanian context in the conclusion of this report.

⁶ <http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html>

⁷ The 'new public health' emerged during the 1980s alongside the Ottawa Charter for Health Promotion and the culmination of a number of existing social movements (feminism, environmentalism) to provide a more critically engaged public health that incorporated wider social, political and cultural understanding of health alongside behavioural and lifestyle understandings previously found under the old public health (Baum 2008).

Traditional explanations for the spatial patterning of health outcomes have distinguished between compositional and contextual characteristics (Bernard *et al.* 2007, Cummins *et al.* 2007, Larsen 2007, O'Dwyer *et al.* 2007). The *compositional* explanation attributes the geographical clustering of health outcomes to the shared characteristics of people⁸, for example SES, who reside within a geographic location. The *contextual* explanation attributes variations to characteristics of the environment, stating that there are ecological attributes of spatially defined areas that affect whole groups, and that they affect health over and above the contribution of aggregate individual characteristics (Bernard *et al.* 2007, Larsen 2007).

Compositional Explanations of Place-based Health Inequalities

Compositional explanations of health inequalities understand place-based variations in health as differences amongst individuals, where such differences are reflected in the observed differences between places (Macintyre & Ellaway 2000). Compositional effects are the result of the 'varying distribution of types of people whose individual characteristics influence their health (Curtis & Jones 1999, 647). Consideration of compositional effects permits population-level analysis of health differences and provides a macro perspective on health inequalities between areas.

Compositional explanations draw upon aggregate measures to describe the relationship between area and health. Historically, such measures describing area effects upon health were based upon individual-level data from census or survey data (Macintyre *et al.* 20002). For example, the Townsend Index of Material Deprivation, developed from 1981 UK Census material, uses data on car ownership, home ownership, unemployment and overcrowded housing. The measure was devised using percentages of these four factors across areas to explore the relationship between deprivation at an aggregate area-level and the differences between mortality and morbidity across areas (Macintyre, Maclver & Sooman 2000). Compositional explanations have also used neighbourhood socio-economic status to describe area-level health outcomes (Picket & Pearl 2000). In Australia, the census-based Socio-Economic Indexes for Area (SEIFA) and, in particular, the Index of Relative Socioeconomic Disadvantage (IRSD) are used by both health researchers and policy-makers to analyse health inequities. These measures are multi-level, and include contextual variables such as wealth, living conditions and access to services (Johnson, Currie & Stanley 2009).

Measures such as these are heavily influenced by the effects of aggregation and are not primarily concerned with area or area effects, but rather with how socio-economic status or deprivation measures can explain observed health differences between areas (Macintyre *et al.* 2006, Curtis & Jones 1999). Compositional approaches have been criticised for making 'inaccurate assumptions' about those individuals within specific populations: 'a purely compositional interpretation of geographical health variation might imply similar types of people will have a similar health experience no matter where they live' (Curtis & Jones 1999, 647). Moreover, compositional approaches to place-based health inequalities may give an inaccurate representation of inequalities:

Poor people would die early wherever they live and rich people would live longer wherever they live; the spatial effect is purely due to the spatial concentration of poor or rich people

⁸ Bernard *et al.* suggest residents may cluster purposefully to share a common culture, or because they are driven to certain areas because of lack of personal resource.

in different sorts of areas, and life expectancy is therefore a property of the individual, not of areas. (Macintyre 1997, 1)

Compositional explanations may neglect the social and physical environments because they fail to capture 'health promoting or health damaging' features of the area (Diez-Roux 2007, Cummins *et al.* 2004).

Contextual Explanations of Place-based Health Inequalities

Contextual explanations of place-based inequities emphasise the impact of the social and physical environment on people within those spaces (Macintyre & Ellaway 2000). Contextual explanations posit that health and illness cannot be divorced from wider social structures (Frolich, Corin & Potvin 2001). Ecological attributes of the environment impact upon individuals, but this impact varies; these attributes may affect all individuals within the area or only some groups (Ecob & Macintyre 2000). Contextual effects are features of both the physical environment, the structure of the local economy and the 'social fabric' of communities and neighbourhoods (Joshi *et al.* 2000).

Macintyre and colleagues (Macintyre *et al.* 1993, Macintyre & Ellaway 2000, Macintyre *et al.* 2000) view context effects upon health and illness as a number of interdependent, intertwining factors:

- physical aspects of the area, such as climate, pollution, quality of air and water;
- access to healthy environments, housing, employment and space for children;
- provision of health, welfare and community services, such as schools, transport, policing and public transport;
- awareness of socio-cultural aspects of the area, such as neighbourhood and community networks (i.e. Neighbourhood Watch), community integration, social and political histories of the neighbourhood and levels of safety and crime, and
- reputation of the area as perceived by residents of the area, members of the community, service providers (i.e. banks), which may impact upon the physical and socio-cultural dimensions of the space.

These factors can be understood as a set of 'opportunity structures': socially constructed and socially patterned 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' (Macintyre & Ellaway 2000, 343). Opportunity structures can also be understood as forms of social capital, in which the amount of, or access to, opportunity structures may have a direct or indirect impact upon health outcomes (Ziersch 2005, Ziersch *et al.* 2005, Veenstra *et al.* 2005, Baum & Palmer 2002).

The level and significance of contextual effects upon individuals' health is inconclusive. While some contextual characteristics or effects appear to have a greater or lesser impact upon health outcomes than others, in general, individual socio-economic status and demographic characteristics appear to have a greater impact upon health than contextual factors.

A critical review of 25 neighbourhood health studies found that individual-level socio-economic status accounts for more variation in health outcomes than neighbourhoods (Pickett & Pearl 2001). Across specific health-related behaviours and illnesses, individual-level characteristics were more likely to explain diet, levels of physical activity, smoking and alcohol consumption in Scotland and

England (Ecob & Macintyre 2000, Ellaway & Macintyre 2009, Karvonen & Rimpela 1996). Similar findings were found amongst those with heart disease in the United States (Franzini & Spears 2003) and in Sweden (Chaix, Rosvall & Merlo 2007). Whilst this evidence suggests place does not matter in the context of health, more recent research drawing upon a wider source of contextual variables has found that some area-level effects appear to be independent of individual-level socio-economic characteristics. For example, neighbourhoods in England and Scotland with higher levels of unemployment and poor access to transport, after adjusting for individual-level socio-demographic characteristics, reported lower levels of self-rated health (Cummins *et al.* 2005). Recent work on area effects and smoking are also indicating that place has an impact on smoking over and above individual socioeconomic characteristics. For example, a study exploring the association between physical neighbourhood stressors and smoking in the city of Eindhoven found that physical neighbourhood stressors are related to smoking and contribute to neighbourhood variations in smoking rates over and above individual level characteristics (van Lenthe *et al.* 2006). A qualitative study of area effects and smoking from Glasgow explored pathways which might explain the association between place of residence and smoking status independently of individual poverty and socio-economic status. This study found that a poorly resourced and stressful environment combined with strong community norms in support of smoking, isolation from wider social norms and limited opportunities for respite and recreation appear to foster smoking and discourage cessation (Stead *et al.* 2001).

Australian data on place and health is more limited but also provides support for the role played by context over and above social composition. In Australia, people living in disadvantaged areas are more likely to report lower levels of physical activity after adjusting for individual socio-economic position and area-level socio-economic disadvantage (Kavanagh *et al.* 2005). Further research has found that levels of overweight and obesity were strongly correlated with disadvantaged areas, especially amongst women, and that area disadvantage was an important predictor of adult body mass index (BMI) (King *et al.* 2005). Mortality rates for Australians living in the most disadvantaged areas were comparably higher than for those living in the least disadvantaged areas between 1985 and 1997. Amongst private and public housing residents in Victoria, Feldman *et al.* (2009) found that area was critical to self-reported health after factoring out compositional differences between areas. A multi-level cross sectional population study of the relationship between area deprivation and health risks and outcomes was conducted in Adelaide (Adams *et al.* 2009). This study aimed to examine the effect of local area socio-economic disadvantage after accounting for individual socio-economic status to determine whether these differ between health and risk factor variables. The results showed significant independent association between the index of relative socio-economic disadvantage (IRSD) at the level of collector districts and obesity, smoking and health related quality of life (Adams *et al.* 2009). A refined version of the approach developed in this study could be used to develop base line data concerning the place-based determinants of health in Tasmania. This evidence base makes clear that both composition and context matter for health and health outcomes. Contextual effects may have a greater and more direct impact upon the health outcomes of individuals living in Australia when compared to some other Western countries where the relationship between place and health is more ambiguous. More generally, context can be understood as impacting upon all individuals to differing degrees but for those living in the most disadvantaged areas the negative impact is greater:

People of whatever levels of personal poverty or affluence might live longer if they lived in non polluted areas with a pleasant climate and an excellent range of services and amenities; or, rich people might live just as long wherever they live because they have the personal

resources to cope with a range of environments, but poor people might die particularly early in under resourced neighbourhoods. (Macintyre & Ellaway 2006, 338)

Whilst compositional and contextual explanations of place-based health inequalities have traditionally been conceived as mutually exclusive or competing, it is probable that the relationship between people, place and health is more complex. It is likely that the composition/context dichotomy is an oversimplification given that area of residence is neither random nor totally intentional. Bernard *et al.* (2007) argue that both chances and choices influence residential decisions which are:

...shaped by the correspondence between individuals' economic means and lifestyle preferences, and neighbourhood characteristics pertaining to the availability of resources and services, the quality of the physical and built environments such as housing, and other socially oriented criteria such as reputation, history or the presence of social connection.'

Larsen (2007) agrees that the distinction is somewhat artificial due to the interrelationship between people and places. People create places and places create people. It is generally recognised that concentrations of disadvantage in certain areas within cities is the result of a complex mix of social, spatial, economic and political forces, and that the local neighbourhood is important in shaping these processes. The interaction between social and spatial processes simultaneously creates both social and spatial inequality (Larsen 2007). In a similar vein Cummins *et al.* (2007) argue that research in place and health reject composition /context dualism by recognising that there is a mutually reinforcing and reciprocal relationship between people and place which needs to be understood if effective, 'contextually sensitive' policy interventions are to eventuate.

Compositional and contextual understandings are useful for public health researchers and policy-makers to understand, explain and investigate place inequalities from a population health perspective. They highlight the population-level characteristics of individuals in an area and also provide an understanding of the physical, social and cultural dimensions of place. Whilst these explanations are utilised by researchers in public health or by policy-makers in understanding the health of others in places, such explanations do not account for how individuals within those places and spaces understand their health or health outcomes. A relational approach to place and place-based health inequalities is needed, one which incorporates the physical, social, political and cultural dimensions of place using the understandings and meanings from the individuals' perspective (Cummins *et al.* 2007).

Re-conceptualising Place

Popay *et al.* (1998) point to the need for a re-conceptualisation of 'place' in health research which takes into account both the historical and the biographical. They suggest the former sees 'place' as the location in which macro social structures impact on individual lives. The latter talks to the lay experience of 'the everyday life-world' which consciously '...explores the connections between the sub-universes which people directly experience and the wider world which shapes those sub-universes' (Popay *et al.* 1998, 634). Places can be conceptualised as locations for 'structuration'—the interrelationship of the conscious intentions and actions of individuals and groups and the 'environment' of cultural, social and economic forces in which people exist. Popay *et al.* (2003, 64) argue that:

...one of the routes that material disadvantage works through in differentially impacting on health-related action and health status is people's ability to (re) construct a positive identity for themselves in particular places despite poor environments. Their ability to do so seems to be linked to the relationship between their personal biographies and the places they are living in as well as their ability to construct a finely differentiated cartography that localises problems within places.

Bernard *et al.* (2007) conceive of place as a unique system of health relevant resources and social relationships enclosed within a geographical border. Neighbourhoods are conceived of as opportunity structures with specific distributions of resources which allow residents to work, learn and interact socially and to participate culturally. These are the social factors which determine health; spatially patterned health inequities are thus rooted in spatially patterned unequal distribution of these resources. Bernard *et al.* (2007) do not see neighbourhoods merely as pools of resources inhabited by passive residents. Rather they see neighbourhoods as spatially defined distribution networks through which resources are accessible for producing health and individuals are active agents in acquiring those resources. Shankardass and Dunn (2011) suggest greater attention needs to be given to the neighbourhood and the phenomena that constitute it—as well as extra-neighbourhood factors—as actively structuring people's health opportunities. Building on Giddens' structuration theory, Bernard *et al.* (2007) claim social structures present both opportunities and constraints that shape and orient behaviour. Simultaneously, social structures are informed, reproduced and transformed by the social practices of agents. Bernard *et al.* (2007, 1842) argue that 'as a social structure, a neighbourhood opportunity structure cannot be conceived independently of the residents' practices in relation to that structure'. The opportunity structures within neighbourhoods are complicated by processes that determine the distribution of resources (authoritative and allocative) related to five domains (economic, institutional, physical, community organisations and local sociability) and individuals who are active agents in acquiring resources, but who are governed by rules in addition to proximity, such as price, rights and informal reciprocity (Bernard *et al.* 2007).

Shankardass and Dunn (2011) propose that epidemiologic studies must move beyond two key assumptions of why neighbourhood health inequalities occur:

- The first assumption is that anyone who resides within a specific high risk neighbourhood bears equal risk for the health outcome of interest. That is, proximity to a hazardous exposure or resource as defined by neighbourhood of residence translates to equal exposure to that hazard or access to that resource. Proximity alone however does not necessarily imply exposure to a health risk or access to a health resource.
- The second assumption is that we can understand a person's risk or access by considering the characteristics of their residential neighbourhood alone with little attention paid to the movement of individuals, both within and outside of their residential neighbourhoods.

Cummins *et al.* (2007, 125) also propose a more relational view which offers a more sophisticated understanding. Space is seen as 'unstructured, unbounded and freely connected'. Human practice forms 'constellations of connections' which extend outside the traditional 'bounded' notion of place. Populations are mobile in their interactions with space on a daily basis and over the life course implying that that individuals influence, and are influenced by, conditions in multiple places. Places are not politically or socially neutral. How areas are represented, delineated administratively, and how services and infrastructure are distributed are the outcomes of social relations and power

struggles within society. Cummins *et al.* (2007, 125) state that 'Places, spaces, flows and circuits are socially constructed, temporarily stabilized in time/space by the social glue of norms and rules, and both enable and constrain different forms of behaviour'.

A relational view argues that places are produced and maintained by the activities of 'actors', proximate or distal to a particular place, who operate individually or in concert across a wide range of geographical scales. These actors may be individuals and community organizations, firms and businesses, regional and national governments and institutions, peer-networks and families, regulatory structures and legislation. Access to goods, services and other assets may in part depend upon geographical availability but also on '...social networks and social power, interventions of various 'actors' and degrees of regulation which produce 'layers' of resources accessible to different members of local populations in different ways' (Cummins *et al.* 2007, 125).

Cummins *et al.* (2007) argue that the relational perspective highlights the need draw on lay information as well as the usual objective indicators of local conditions in order to understand how individuals interpret the context in which they are situated. Places need to be characterised and understood in a multi dimensional way that incorporates resident reports, systematic observation and objective measures on the location and spatial accessibility of resources. They propose that 'personal 'time-space biographies' would allow for the notion that movement (and thus exposure) varies from person to person and is associated with individual socio-demographic and cultural factors such as age, sex, employment status, ethnicity and religion' (Cummins *et al.* 2007, 125). A relational approach allows places to be understood as dynamic and constantly evolving entities, rather than fixed entities, which have positive and negative consequences for the people located within them.

To incorporate relational understandings of how place influences health into empirical analyses it is necessary to:

- Collapse the false dualism of context and composition by recognising that there is a mutually reinforcing and reciprocal relationship between people and place. Having such a view prompts an analysis of processes and interactions that occur between people and the social and physical resources in their environment.
- Recognize that 'context' and 'place' varies in time and space. Charting an individual's personal geography through multiple 'places' and 'contexts' over the day, week, month or even the life course, will give improved measures of exposure and allow for better understanding of which environments are most salient for health in terms of location and duration and how an individual's personal characteristics mediate this relationship.
- Incorporate scale into the analysis of 'contexts' relevant for health. Understanding the appropriate level, from the local to the global, at which 'contextual' processes and actors operate as well as the spatial scale at which their impacts are expressed, is important in order to deliver effective 'contextual' policy interventions (Cummins *et al.* 2007).

McLaren and Hawe (2005, 6) propose an ecological perspective which '...encompasses context in the broadest sense of the word, to include physical, social, cultural, and historical aspects...' as well as attributes and behaviours of persons within place. Such a perspective includes interdependence and mutual interaction among persons/organisms and settings, as well as an emphasis on studying behaviour in natural (non-experimental) circumstances. This ecological approach is echoed in O'Dwyer *et al.*'s (2007, 330) suggestion that '...area should not be used merely as a way of describing

the bounds of a project, but rather as a determinant of access to services employment, education and social life and as a context for social processes’.

Extending this perspective, Bradford’s (2005) concept of ‘milieux’ combines the material and mental experience of place. Place is conceptualised as dynamic locales with their own diversity and power relations where forces and flows which structure daily life are contested and given meaning. Bradford (2005) posits five ways in which local milieu impacts on citizens:

- *Economic Innovation* – reliant on social networks, personal interactions as well as assets.
- *Social Inclusion* – limited connections and inadequate services multiply disadvantage.
- *Environmental Sustainability* – local land use, transportation, and residential and commercial development influence social sustainability and public health.
- *Citizenship Right* – access and inclusion in local places impact on quality of life for all citizens. The effects are manifest in prospects for employment, housing, health, personal safety, and cultural recognition.
- *Sense of Belonging* – community heritage of natural, built-form and cultural resources create shared points of reference and foster a sense of community or neighbourhood identity.

The notion of ‘place’, then, is indispensable to individuals’ understandings and experiences of health and well-being (Popay *et al.* 2003). Place is the intersection of the behaviours and actions of individuals and groups as well as the cultural, social and environment in which they exist (Williams 2004). The meanings individuals give to places and their experiences of places and the articulation of these meanings—this lay knowledge—provides a greater understanding of the intersections between individuals and wider social structures.

Lay Knowledge and Place

Lay knowledge is representative of individuals’ social and economic position—their life chances and life experiences and the imprint of society upon their lives (Macintyre, McKay & Ellaway 2000). Popay *et al.* (1998) argue that lay knowledge represents a ‘privileged’ form of expertise about inequalities in health and this may challenge existing forms of expertise from policy, research or health professionals. This finds resonance with Wainwright (1994, 81) who argues that the challenge is to ‘see like a community’ which validates ‘...the very mundane, but still expert, understanding of and practical reasoning about local conditions derived from lived experience’. Seeing like a community taps into forms of knowledge that are generally unacknowledged in public policy making. Thus, understanding lay knowledge can provide critical insight into the relationship between health and place; how place and places impact upon individuals’ experiences of health and conversely, how individuals negotiate place and the effect it has on their health.

Lay knowledge can be thought of as narratives or accounts of individuals’ personal experiences and biographies. Narratives are accounts of lived experiences; they are ‘representations of the ontology of experience’ (Williams 2004). A narrative approach allows researchers and policy-makers to move beyond a causal model of health towards an understanding of how people experience, understand and internalize the social conditions that structure their actions and its consequences for their health. Narratives provide a context to the experiences of health and illness, particularly

explanations that centre upon risk behaviours, by looking at the 'wider material and environment conditions' of which the risk behaviour is situated' (Williams 2004, 1).

Tapping into lay knowledge can provide insight into the effectiveness of population health policies and health promotion strategies as well as insight into the differences between lay and professional understandings of both problems and solutions. Lay knowledge is 'unique' and is likely to differ from or even contradict professional and expert knowledge about health and illness. As Macintyre, McKay and Ellaway (2006, 731) observe:

...if members of the public do not share professionals' beliefs about key influences of health (for example, if they do not believe that smoking is health damaging) they are less likely to be persuaded to adopt professional guidelines for strategies to manage or prevent illness'. It is from narratives of lay knowledge that health promotion and policy can be tailored.

Despite the premium of lay knowledge and the potential to provide insight into how individuals understand health inequalities or health differences within and amongst populations and places, there has been little research into this area since Popay and colleagues in the late 1990s. The small evidence base that does exist is inconclusive. Macintyre, McKay & Ellaway (2005) argue that more socially disadvantaged people are less likely than the more advantaged to understand the impact of socio-economic inequalities and the social causes of health and health inequity. However Davidson *et al.* (2006) found that the socially disadvantaged are not only aware of their social position and how it impacts on their life opportunities but realise that this also impacts on their health, especially their mental well being.

Calnan (1987) found differences between how women of lower and higher occupational-based classes understood health differences; women in lower class groupings were less likely to observe the social gradient on health. Blaxter's (1997) review of lay perspectives of health and illness found that evidence drawn from surveys suggested that individuals, regardless of social class, did not acknowledge, or reconcile the impact of, social structures upon health outcomes. However within the more qualitative-based literature there was some acknowledgment of both individual and structural understandings of health and illness. As Popay *et al.* (2003, 268) observed, Blaxter's review involved 'samples of people in particular places at particular times', concluding that both place and biographical time is important to the 'material places' in which individuals live and their experiences with health and illness.

Building on the work of Calnan and Blaxter, Popay *et al.* (2003) investigated how people from affluent and disadvantaged areas in North West England, understood and explained health differences between different places. They found those from more affluent areas acknowledge the existence of health-related disparities between areas but those in more disadvantage areas denied the differences between areas. Moreover, the assumption that particular social groups have different levels of health was rejected by those from disadvantaged groups. Further, any suggestion of 'inevitable' experiences of poorer health and illness due to place of residence was also rejected. Despite this, people in the disadvantaged areas did unintentionally contradict themselves by detailing the negative impact of place upon their health. In instances where such inequities were acknowledged, this contradiction was explained through 'narrative (re)construction' which emphasised the importance of resilience and personal control as a way of limiting health damaging effects: in other words, while a person may be exposed to considerable social, material and psychological risks to their health, it is their response to the risks that determines any subsequent damage to health (Popay *et al.* 2003). The critical link between how people understand their health and the places they inhabit are the 'normative guidelines' or shared meanings and understandings of

what constitutes a proper place' (Popay *et al.* 2003). Popay *et al.* (2003) would claim it is the 'dissonance' and 'concordance' of normative guidelines that differentiates health experiences.

There has been limited research in Australia on place and narratives of lay knowledge. Adelaide-based public health researchers, Putland, Baum and Ziersch (2011) found that despite recognition and awareness of the structural causes of health inequalities, the tendency among lay people was to focus on individual behaviours and attitudes and to express the view that solutions to health inequalities lay with individual responsibility and behaviour change. This was in contrast to some previous research that found more divergent views between advantaged and disadvantaged groups (Macintyre *et al.* 1993). Putland *et al.* (2011) concluded that this demonstrated that public health research and policies regarding the social determinants of health have not had a substantial impact upon individuals' understandings of health and illness.

Popay *et al.* (1998, 636) suggest that the '...meanings people attach to their experience of places and how this shapes social action could provide a missing link in our understanding of the causes of inequalities in health. These meanings or 'lay knowledge' in narrative form could provide insights into the relationships between human agency and wider social structures that underpin inequalities in health. This narrative form provides a different perspective on the relationship between individuals and the places, or 'relational settings' in which they live. This perspective makes 'place' more than a set of static environmental resources and the 'lifecourse' more than a biological trajectory during which the individual is exposed to risks or benefits. It highlights the need to understand the meanings people give to the relationship between significant events in their lives. In the context of inequalities in health it provides a strong case for looking at people's perceptions of 'episodes' in their lives and how they impact on subsequent actions (Popay *et al.* 1998).

Implementing Place Based Policy

In order to develop policies to improve public health and identify points for intervention there is a need to estimate the magnitude of and understand how far relationships between health and places are generalizable (or variable) across whole populations.

The link between poor health status, social inequality and locational disadvantage requires a policy response which tackles health inequality at its source (Klein 2004). Place-based policy targets specific neighbourhoods or communities for integrated interventions that respond to location-specific challenges, and engage fully with the ideas and resources of residents. The aim is both better public policy and more community capacity. In political terms, the place becomes a locus for the mobilization of collective action, generating a community of meaning and practice for those living there (Bradford 2005). The focus is on all major determinants of health in a certain location rather than on a single risk factor. The combination of community development and area regeneration strategies and well coordinated and comprehensive interventions in disadvantaged areas offer the potential to break the '...vicious cycle of poor health and poor socioeconomic status' (Dahlgren and Whitehead 2007, 108).

Bradford (2005) suggests that place based approaches are a way of tackling 'wicked' problems which are resistant to traditional sectoral interventions designed and delivered in a top down manner. These problems require context dependent policy intervention, structured by particular knowledge and delivered through collaborative mechanisms. 'Wicked problems require the combined insights and actions of multiple actors learning what works in particular places and knowing how to make it happen on the ground' (Bradford 2005, 4).

Place based policies target geographical areas of deprivation and commonly comprise investment in key socioeconomic determinants of health, for example employment, housing, education, income and welfare (Thomson 2008). These approaches are attractive because they allow for local involvement and ownership and many interventions or policies may be intrinsically area based, such as education, housing and health services (Macintyre 2007). However, addressing entrenched locational disadvantage requires more than delivering services or linked-up, locally tailored services. It also requires the long-term engagement of all tiers of government and the local community (including business and non-profit organisations) in taking joint responsibility for the problem, and in having the support to address the issues (ASIB 2010b).

An effective place based approach needs to reconceptualise the role of government away from providing services to disadvantaged areas and towards investing in building community capacity and leadership. It requires local definition of both problems and their solutions, the use of local expertise and engagement with local resources. As local engagement builds, decision making is devolved away from government and to local institutions, a process which builds the capacity of those institutions. It builds sustainability through strengthened local communities which have acquired the tools to react independently to current and future problems.

The Australian Social Inclusion Board (ASIB 2010b) identifies five key elements to making this approach work in disadvantaged locations with entrenched social problems. The first is to align the economic and social policies operating in the region predicated on the need for a strong economic foundation to underpin social improvements. Secondly, all levels of government need to have a shared focus and coordinated approach. Thirdly, meaningful local engagement in substantive policy development and delivery is required. The fourth element is a commitment to building capacity in both the community and the public service to allow engagement and devolution to occur. The fifth and final element is funding and accountability processes which are suited to this different kind of approach. Specifically, there is a need for long term funding in recognition that community engagement and development is a laborious process and deeply entrenched disadvantage cannot be expected to be reversed quickly. Further flexibility is required so that policy responses can evolve as the issues themselves evolve.

Area based programs to improve the physical, social and economic environment and address socioeconomic deprivation as a pathway to improved health are not a new idea. Urban renewal and place-based interventions have tended to focus on positive change at the level of people, place or space. Space refers to the physical environment of disadvantaged neighbourhoods. Place refers to the meaning and use of space such as social networks and the economy (Larsen 2007). One major change in the types of intervention being used has been the shift away from purely physical (space) interventions to a more integrated and holistic approach. In particular there has been greater emphasis placed on social interventions such as community development, education and employment (Larsen 2007).

Importantly, a place based approach influenced by Popay *et al.* (1998) would also make greater use of lay knowledge which represents a 'privileged' form of expertise about inequalities in health and this may challenge existing forms of expertise from policy, research or health professionals. Wainwright (1994) also advocates for policy makers to make better use of lay knowledge. As noted earlier, Wainwright suggests the challenge is to 'see like a community'. Similarly, Bradford (2005,5) uses the term *experiential knowledge* to describe people's assets, needs and capacities, based on close familiarity with the local circumstances and its role in structuring peoples' choices concluding that '... Listening to people, and mapping their interactions in places, turns out to be important for

effective policy-making'. Bradford (2005) also differentiates between *tacit knowledge* and codified, scientific knowledge. Tacit knowledge, described as informal practices, know-how, imaginative ideas, circulates through the face-to-face interactions of geographically proximate actors and is believed to play a key role.

Effective policy, then, requires tapping into three different types of knowledge:

- Knowledge *of* communities: based on clients' lived experience of 'their' place; frequently expressed in narrative form by residents (situational knowledge).
- Knowledge *about* communities: statistical data disaggregated to the local scale, tracking trends in the city or community and mapping assets (technical rational knowledge).
- Knowledge *for* changing communities: theoretical models that articulate plausible links between reform strategies and outcomes. Such models build on understandings of the factors that have produced success or failure in different places, and they guide community-based practitioners and policy makers in setting priorities (action research knowledge) (Bradford 2005).

By tapping into these different knowledge bases, the concept of evidence is recast. When the 'facts' are seen as constituted by particular contexts and experiences, rather than as external objective truths, meaningful policy knowledge cannot be detached from the situated problems or the people experiencing them. Policy development becomes 'a two-way translation process' whereby formal knowledge is reworked so that it can be applied to the specific situation and lay knowledge is articulated and validated as formal knowledge. The policy maker role shifts from that of technical expert to 'facilitator of and participant in community driven learning, planning and action' (Bradford 2005, 6). Similarly, Parker (2007) identifies a need for government to facilitate a 'network' approach and create an environment where all parties, including consumers, are co-producers in the design and delivery of services and the creation of public value.

Pickin *et al.* (2002) have identified a number of challenges to developing the strategic partnerships that would fully incorporate lay knowledge into policy making. Professional attitudes overestimate the value of professional knowledge and take a paternalistic view of the public as passive consumers of health care rather than active (co) producers of health. The norms and practice of professionalism are exclusionary and there is a lack of skills and time to meaningfully engage with the community. Short funding cycles are contrary to proper engagement or to building community capacity for engagement. Professional service culture is dominated by issues of power and control which gives precedence to professional knowledge over lay knowledge (Picken *et al.* 2002). Communities are perceived in terms of deficits rather than assets. While they may have a role in defining their issues, communities are not deemed to have the competencies to develop solutions.

O'Dwyer *et al.* (2007, 329) in their systematic review found 'some evidence' that place based interventions reduce health inequities if:

...there was a change or difference in the physical environment; funding was adequate; there was good leadership and partnership with communities; there were appropriate and well-designed programmes; political support was firm; the objectives did not change over the course of the programme; and the size of the area was appropriate to the particular inequality.

Much of what is known about area based initiatives for improving health inequalities comes from the British experience of Health Action Zones (HAZ)⁹ implemented in 1997. Bradford (2005) describes HAZ as a two phase policy development framework with targeted initiatives to stabilise distressed neighbourhoods and then mainstream policy lessons learned. HAZ had two health inequalities objectives:

- To improve health outcomes and reduce health inequalities in their areas which were mainly located in disadvantaged communities; this was expected to reduce both local and national inequalities.
- To develop new ways of tackling local health inequalities by investing in innovative initiatives and establishing effective ways of learning from them. They were expected both to mainstream successes internally and to disseminate good practice more broadly to the health community (Bauld *et al.* 2011).

This was to be achieved through new governance structures and processes such as partnership boards, community involvement, targets for potential achievements, including early wins, and performance management systems that would monitor and demonstrate progress with reference to agreed milestones¹⁰. However, by 1999, due to policy shifts at the national level, there was a change in direction of the zones. Concern by central government over the ability of HAZs to plan and implement activities resulted in the introduction of a performance management framework which demanded that HAZs report quarterly on progress towards specific longer-term objectives and eventually the HAZ were reabsorbed into mainstream health funding. Ultimately the HAZ became more of a top-down initiative than was initially envisaged (Bauld *et al.* 2011).

Bauld *et al.* (2011) found that HAZ were unable to realise their potential for a number of reasons. The time span was too short for any measurable impact on health outcomes and the HAZ were encouraged to set what proved to be unrealistic goals. There was a disconnect between the top down programmatic goals-driven focus of central government and the lateral cross agency model of

⁹ HAZ were a major policy initiative of Blair labour government comprising multi agency partnerships in 26 severely disadvantaged areas of England. They had three strategic objectives; identify and address the public health needs of the local area; increase the effectiveness, efficiency and responsiveness of services; and develop partnerships for improving people's health and relevant services. See Bauld *et al.* (2011), Judge and Bauld (2007)

¹⁰ Bradford 2005 describes complex governance structure to ensure program coordination, partnership support and accountability.

- Local strategic partnerships (LSA) at community level but including representatives from national agencies.
- Existing Regional development agencies developed regional economic plans- coherence of local strategies with region.
- Regional Coordination Unit—program coordination.
- Public service agreements included performance targets—accountability.
- Service delivery agreements were the implementation plans—accountability.
- Community empowerment fund—build community capacity.
- Community chest—small grants scheme.
- Learning Curve- knowledge management and transfer.

area based initiatives. It was questionable whether local planning structures could alleviate intractable social problems or if a modestly funded local initiative could tackle a fundamental structural problem such as health inequalities. Despite this, Bradford (2005) claims the HAZ policy framework moved beyond the simple dichotomy of a top-down imposition of central government priorities and a bottom-up competitive scramble among localities for funds. Further, some legitimacy and capacity was restored to local governments, recognizing them as vital partners in local collaborations and rewarding them for working in new ways. The strong emphasis on coordination and integration meant that neighbourhood-based projects would have to dovetail with regional strategies and connect to mainstream policy.

There is general agreement that major reductions in poverty and the resultant social and health inequalities require major economic structural reforms and that progressive macro social and economic policies are key instruments for tackling inequalities in health (Bauld *et al.* 2011, Klein 2004). Bauld *et al.* (2011, 441) note, however, that it:

...does not necessarily follow that local investment across the range of complex determinants of health cannot contribute to reducing the health divide ... Moreover, complex social problems require a flexible policy framework that allows for differential response locally in relation to differing needs.

To Klein (2004), the concentration of inequalities in particular places points to the need to supplement universal policies with targeted place base responses.

Judge and Bauld (2006), Bauld *et al.* (2011), and Bradford (2005) agree that HAZs did make a valuable contribution to building partnerships and raising awareness regarding inequalities in health. Further, HAZs promoted a greater understanding of the determinants of health and gained ownership of the range of partners necessary to address health inequalities. There was some success in building collaborative capacity with a positive impact on service provision which contributed to better health for HAZ clients. Halliday and Asthana (2005, 187) found:

... tentative evidence to support the efficacy of partnership working within one HAZ. They have gradually increased community involvement and community advocacy, reshaped organizational attitudes, challenged the boundaries of accepted health-related activity and increased the strength and connectivity of local networks. Benefits to users from this process are also evident, including improvements in health related attitudes, knowledge and behaviour ... the development of additional facilities ... and services tailored to local need.

However they found that change was at the behavioural and individual level rather than producing the social or political change necessary for community empowerment.

The HAZ experience demonstrated that partnership governance at the strategic level is difficult in a Westminster system of responsible and accountable government. It is difficult for central government to let go of decision making power when it is they who are accountable to the public. Bauld *et al.* (2011) found that HAZ were more successful in demonstrating the potential of new governance arrangements below the strategic level and that cross sectoral partnerships and community involvement worked better within smaller localities rather than across broader geographic areas.

Even in those areas where examples were given of community members being involved in processes that shaped the development of the HAZ, there was also an awareness of the limits to this, not least because formal rules constrained the extent to which accountability

for health services and policy can be expressed downwards to local communities. (Bauld *et al.* 2011, 439)

This finding is especially relevant to the development of place-based policies in a federation where State governments are best placed to make strategic local interventions. Bauld *et al.* 2011 further note that a key lesson from the HAZ experience is that there is no single blueprint for addressing the complex causes of health inequalities at the local level. However, there is understanding to be gained from different attempts in specific contexts to promote change and this demonstrates a continuing need for a dedicated policy focus on health inequalities at the local level.

In the Australian context, the Neighbourhood Renewal Victoria (NRV) program provides perhaps the most relevant place based social model of health which goes beyond orthodox biomedical and behavioural responses to health inequality. It focuses on improving the socioeconomic opportunities of residents in disadvantaged communities through local job and enterprise creation training and educational strategies. It is a targeted response to spatial concentrations of inequality and intervenes in key pathways to morbidity/mortality by transforming poor housing, creating employment opportunities, improving education, rejuvenating local economies and building social capital. Further, it tackles health risk behaviours through context sensitive health promotion and addresses psychosocial needs through comprehensive community strengthening strategies. It has a joined up governance model and place management arrangements which strengthen the capacity of communities and encouraging local solutions, engaging residents as active citizens (Klein 2004). Klein (2004) claims this represents a paradigm shift from:

- treating symptoms to targeting sources of inequity; fragmented reactions to integrated solutions; and paternalistic service provision

to:

- social investment and citizen participation that devolves power to communities.

The success of social health initiatives is premised on effective coordination, a governance model which facilitates action across multiple agencies and strategic partnerships between residents, local government, local business and regional offices of State government. In NRV, a 'place manager' manages across programs to deliver cross cutting outcomes and a steering committee and working group develop and implement community action plans. Existing programs are integrated to maximize the multiplier effect, there are flexible funding arrangements and the role of citizens to influence social investment is strengthened. Taking the participants' frame of reference into consideration *and* sharing power and control is crucial to improved health outcomes. The policy context shifts from one of 'problem people' to people as part of the solution, building the capacity of individuals as decision making citizens (Klein 2004).

Neighbourhood Renewal links community engagement to social investment and economic development that impacts positively on life in disadvantaged communities. In the partnership that results, residents have a stronger role in influencing local investment and service provision. Formally this is achieved by governance arrangements, which require the inclusion of 50% local residents, as well as representatives from government and other stakeholders. These arrangements empower residents to participate in planning, decision making about priorities for action, implementing change with the support of government, and evaluating the success of local initiatives. (Klein 2004, 117)

On reviewing program we believe that a modified version of NVR has the potential to address place-based health inequality in Tasmania. Indeed much of the community and governance infrastructure,

such as a network of community houses, and could be used to develop, deliver and evaluate place-based health policies.

Internationally, the US has a history of relatively ineffective urban renewal policies dating back to the 1960s. However, there has been a number of key learnings from these policy failures: adequate local knowledge and intergovernmental collaboration is crucial to success; evaluation frameworks must be built into programs at the outset; some neighbourhoods cannot be revitalized without connection to the wider labour markets, housing markets, and commuting patterns; and emphasis on the manifest 'deficits' of troubled neighbourhoods overlooked latent community 'assets' that could be leveraged for success. In the 1990s, the US emphasis shifted to a 'place-based people strategy' which integrates general, aspatial social policies for individuals in their family context, and targets spatial interventions for individuals in their community context. The 1993 Empowerment Zone and Enterprise Community program (EZ/EC) is representative of this hybrid framework (Bradford 2005).

Four priorities framed the EZ/EC program: economic opportunity, community-based partnerships, sustainable community development, and strategic vision for change. Strategic plans were required to include benchmarks for measuring success, including the extent to which poor persons would become empowered. The effective implementation of EZ/EC programs was assisted by two factors: the presence of an existing organization in a neighbourhood that was ready to lead (such as the Tasmanian Association of Community Houses), and the linking of that neighbourhood organization to wider metropolitan economic growth and workforce development activities. The success or otherwise of the program remains contested. The empowerment efforts have been judged, by some analysts, as modest and compromised by an overall social policy agenda which dismantled the existing welfare system. Others report '...evidence of "stunning progress" in reducing spatially-concentrated poverty, particularly among African Americans, and growing home ownership and minority owned businesses in inner cities' (Jargowsky, 2003 cited in Bradford 2005, 25).

Bradford (2005) notes that there are a number of cross-pressures which require careful management in the implementation of place based approaches:

- *Neighbourhood and regional scales.* Close attention must be paid to the particular needs, assets, and capacities of specific neighbourhoods at the same time that local strategies connect to wider metropolitan or regional opportunities.
- *Targeted and aspatial policies.* Comprehensive urban policy must integrate spatially-targeted interventions with general, aspatial programs. The challenge is to capture the synergy between the different scales of policy action.
- *Jurisdictional autonomy and policy interdependence.* Political leaders seeking solutions to spatially-concentrated problems must develop collaborative approaches that respect formal jurisdictional divides but equally recognize the fact of policy interdependence on the ground, and work pragmatically through such common ground.
- *Evidence-based decision-making and policy learning.* Sound urban policy requires evidence based decision-making that draws on different kinds of knowledge inputs and is open to learning over time.
- *Pressures for results and patience for collaboration.* Successful collaborations take time as they ask governments, departments, and societal organizations to define shared goals and work together, often for the first time. Trust relations must develop and new capacities for

collective action must be built. Clear evaluation frameworks need to be built into the collaborations from the outset, but benchmarking success must allow that the appropriate time frame may be one or two decades, not years.

- *Collaborations may combine the organizational logics of hierarchy, networks, and competition.* Multi-level governance draws on the different principles of social organization: hierarchy, markets, and networks. The local partnerships at the heart of the model express the networks' trusting relations. At the same time, the need for accountability reintroduces forms of hierarchy as upper level governments monitor local performance and evaluate results. Governance must respect local autonomy and diversity while also deploying more directive tools to reward excellence and safeguard equity across localities.

Bradford (2005) further reports that, to date, results from multiple jurisdictions (US, UK Europe) remain inconclusive but each has made some progress in tackling the complex social and economic challenges of disadvantaged places. Establishing the efficacy of place-based initiatives, policy and planning is challenging and the lack of well-designed outcome evaluations limits the extent to which firm conclusions about their effectiveness can be made (O'Dwyer *et al.* 2007, Thomson 2007 Melbourne Centre for Community Child Health). Compounding this problem are the numerous and changing variables that are not measured by an evaluation. These make it difficult to clearly link an intervention and measured outcomes (Chapman 2004 cited in ASIB 2010). Thomson (2007) agrees there is still a lack of validating evidence that place based programs work and much uncertainty around whether area based initiatives impact positively on the socioeconomic determinants of health and health inequalities. However this uncertainty could be due the absence of evidence rather than evidence of absence.

Governance for Place Based Interventions

Multi-level collaboration and policy partnerships raise difficult *accountability* questions. Attribution of credit or otherwise is not clear cut and new forms of collaborative decision making are not necessarily democratic or transparent (Bradford 2005). Where policy-making through functional departments has existing lines of accountability for decision making and allocation of resources, multi-level collaborations need to establish governance structures and processes which ensure accountability. Partnership models give non-government actors a voice in decision-making but this has implications for risk and accountability. Partnerships rely on trust; hence governance models need to include mechanisms for building and maintaining trust (ASIB 2010b).

Governance is about the collective capacity to set policy directions, implement them, and adjust as circumstances warrant. Governance can enhance the overall policy capacity of the political system as input and feedback circulates among actors from different sectors and scales of engagement (Bradford 2005). ASIB (2010) sees governance as being the structures, processes and relationships that determine how a group of people organises itself and makes decisions. They specify three strands:

- Governance of government—the structures and processes by which government decisions are made.
- Community governance—structures or processes put in place to allow a specific community to participate in decision making that affects them.

- Organisational or corporate governance—the way in which the organisation makes and implements decisions, manages its resources, represents its stakeholders and works to achieve its objectives through its legal structure, legal status and decision making processes, and its interaction with government.

Bradford (2005, 10) cautions against a ‘... simplistic or naive view of governance design and operation’. Managing the transaction costs of collaboration require new styles of leadership and facilitation, and the cultivation of trust and respect among the players. It also implies appropriate institutional design such that the collaboration permits monitoring of commitments and accountability for outcomes. Bradford (2005) states that ‘going local’ has three interconnected elements:

- Cultural—spatial proximity allows for face to face interaction that allows better information sharing and inclusive communication with the prospect of greater trust and a greater stake in positive outcomes which residents can share.
- Institutional—localities are settings where civic associations can flourish and social, economic and environmental organisations can join up, resulting in institutional thickness spawning multi sectoral coalitions.
- Political—local leadership is needed to leverage the assets and mobilise the community. Strategic brokers or local champions who can facilitate change and navigate diverse interests are needed.

Characteristics of Successful Place Based Interventions

A number of characteristics have been identified for successful place based interventions. Central to success is that communities participate, lead and ‘own’ the intervention. Investment in capacity building, realistic time frames, adequate funding and strong leadership from government are necessary. Effective relationships between stakeholder groups characterised by high levels of trust and communication, the establishment of shared vision and values between service providers, and effective governance structures are vital. Processes to rigorously measure and evaluate outcomes need to be built into the project from the start. As well, the scale of the project needs to be appropriate to the policy challenges it addresses and it must meet the identified needs of the community and be culturally appropriate (Melbourne Centre for Community and Child Health). In this light, Larsen (2007) found that:

- Improvements to housing can have positive effects on physical and mental health.
- The most successful housing improvement interventions are fully implemented, that is, not prematurely discontinued, and tackled in tandem with other social problems.
- Improving access to health services is likely to have substantial health benefits.
- A mixture of people focused and place focused interventions are more likely to achieve sustainable outcomes.
- Investment in the education of children is a key strategy for improving life opportunities and breaking the cycle of intergenerational disadvantage.
- Skills training and employment initiatives have shown some success.

- There is limited empirical research on health outcomes due to place based interventions because of the difficulties of conducting research in this context.

Critiques of Place Based Approaches

Three main critiques of the place based approach are:

1. Disadvantaged people do not always live in disadvantaged areas.
2. Locally based policy initiatives do little to impact on the macro issues which shape economic and social policy.
3. Timescales and governance arrangements do not sit easily within existing concepts of accountable and responsible government.

Areas of deprivation are reasonably easy to identify. However, this is not the same as identifying deprived people or households because not all deprived people live in deprived neighbourhoods. The potential negative effects, from an equity-in-health perspective, are that those who live outside the target area do not benefit from the intervention (Bradford 2005, Dahlgren & Whitehead 2007, Macintyre 2007, Thomson 2007).

An over-reliance on place-based policy could deflect from the reality that the complex problems of health inequalities originate in structural forces well beyond the municipal boundaries. The root causes of economic deprivation and social exclusion have deeply rooted societal and well as spatial dimensions. There is a need to ensure that spatially targeted approaches are complemented by universal policies: health, welfare and redistributive policies remain important to ensure adequate levels of income support, child care, health care and educational opportunity. Bradford (2005) suggests these universal policies need to be informed by an 'urban lens' that assesses their spatial impact and takes account of local community needs and capacities.

Summary of What We Know and What This Means

- Health inequities are, in part, socially constructed therefore amenable to change.
- Social Determinants of Health (SDH) are socioeconomic, environmental and cultural. These are the upstream measures that create health and sit largely outside traditional understandings of health systems.
- Changes to determinants occur at the macro policy level. Welfare, redistribution, taxation, employment, and education policies which deliver fairer outcomes to citizens should impact on health inequities.

- Health risk behaviour is not simply a matter of choice but is also constructed by cultural, environmental and socioeconomic factors (i.e. the SDH).
- It is the social gradient or *relative inequity* that is damaging to the health of the disadvantaged. This is a psychosocial impact. Policies that create a fairer society should even out the social gradient.
- There is a complex relationship between people, place and health. People who live in disadvantaged areas are more likely to be socially excluded, poor, unemployed, have low educational attainment and less access to material resources. These are all risk factors for poor health behaviours and outcomes. However, not all disadvantaged people live in disadvantaged areas.
- Place is more than spatial; it is also relational and a site for constructing meaning.
- People's connection to place is both historical and biographical.
- Lay knowledge is an important variable in constructing policy problems and the policy responses. Lay knowledge is accessed through narratives which explore different meanings and understandings of health risk and health outcomes and their connections with culture, society and place.
- Policies which improve the health of whole populations may not necessarily impact on the social gradient and may make the social gradient worse. This implies that those who are most disadvantaged need additional targeted measures to help them catch up to the most advantaged in terms of health outcomes. This is the 'leveling up' approach.
- Place based policies which tackle local infrastructure, employment, educational opportunities, and access, build community capacity and social capital and empower communities should impact on the health of local disadvantaged residents but may not impact on disadvantaged people outside that area.

But:

- Place based policies do not tackle the macro policy levers which create a fairer society. They may improve particular disadvantaged areas, build partnerships, and tap into local community 'assets', all of which may result in sustainable change.
- Place based initiatives need governance structures which create partnerships between government, community and local organisations. These are likely to challenge existing power relationships and have accountability risks for government.
- The evidence base for place based interventions is not strong due to few formal evaluation studies and the need for a long term perspective.

Systemic Knowledge Gaps Identified in the Literature

Governance models for place based initiative

The Australian Social Inclusion Board (ASIB 2010a,9) reports that the literature identifies appropriate governance models as being critical to the success of place based initiatives but that details on what

makes a successful model is limited. Identifying the key characteristics of good governance in location based initiatives and making them available to government is of 'critical importance'.

Understanding the social mechanisms of causation

Shankardass and Dunn (2011) found that social epidemiology has been proficient at describing patterns in neighbourhood health inequalities, and modeling them, but less capable at fostering an understanding of how these effects relate to the social mechanisms of causation that underlie such inequalities at multiple levels—including with respect to neighbourhoods and more macrosocial contexts.

Popay *et al.* (2003, 241) claim that the 'aetiological role of the social structure (is) unquestioned by epidemiology which sees only 'the 'host', the 'agent' and a limited number of environmental factors', ignoring the social relationships within which these factors are embedded. What is needed is an epidemiology which penetrates beneath the statistical associations 'to the underlying socio-economic and historical context in which these associations are located'.

Abel (2012, 1) states that 'While empirical evidence continues to show that low socio-economic position is associated with less likely chances of being in good health, our understanding of why this is so remains less than clear'.

Extending concepts of place

According to Cummins *et al.* (2007), '...advancing our understanding of how places relate to health will require moving beyond existing conceptualizations of 'place' in empirical research. This development is necessary in order to fully comprehend the complex relational spatial interdependencies which exist between people and places. Recognizing that individuals can become relationally embedded in multiple health damaging and health promoting environments, across time and space, and at multiple scales is crucial if we are to further understand the importance of 'place' in the generation of health inequalities.

Synergetic effects of multiple risk factors

Dahlgren and Whitehead (2006) posit that 'Research on the synergetic (reinforcing) effects of different clusters of risk factors typical of low-income groups is still quite limited. The WHO Task Force on Research Priorities for Equity in Health has therefore recommended that high priority should be assigned to research that focuses on the interrelationships between factors that change the likelihood of achieving or maintaining good health at the individual level and within the social context.

Popay *et al.* (2003) found that there is a failure to capture the complexity of causal explanation in the health inequalities field, particularly how social organisations, processes and relationships generate inequalities. In part this is due to the positivistic philosophical foundations and empiricist methods' which underpin traditional epidemiological research. This bias means that the focus is on single factor studies and experimental design where 'social relationships' are treated as another variable or risk factor.

Social exclusion

The Social Exclusion Knowledge Network has identified relatively little empirical research focusing explicitly on the relationship between social exclusion and health inequalities. There are, however, significant bodies of research that focus either on a particular dimension that people are 'excluded

from' or particular groups assumed to be affected by or at risk of social exclusion (Mathieson *et al.* 2008).

Agency

There appears to have been relatively little empirical research on the potential for agency amongst those groups most severely affected by exclusionary processes (Mathieson *et al.* 2008).

Abel (2012, 2) states that 'Today there is a near unanimous recognition that concern with the production and reproduction of health inequalities must take into account both the social structure and individual agency to be given credence. Yet we suggest that this literature, while helpful in moving forward the field by underlining and explicating the importance of both, has left some questions open with regard to how structure and agency are linked in the production, reproduction or reduction of health inequalities.

Three particular facets of social inequality in a theoretically meaningful way: 1) membership in lower social classes is typically associated with low capital ownership, limited access to and control over structural resources for health and a lesser ability to convert capital, through their interaction, into health; 2) different forms of capital and their interaction provide for ranges of options (capabilities) from which individuals can choose in practising health-relevant agency; and, 3) depending on the capital available some forms of agency may yield improvements in the structural conditions of health enhancing behaviours and beyond (Abel 2012).

Impacts of areas based initiatives

As Thomson (2008, 37) notes:

It is well established that little is known about the impacts of ABIs. This dearth of evidence would appear to be largely due to a lack of research, suggesting that there is potential for new primary studies to address this knowledge gap. The past decade has witnessed calls for more evidence to support public policy generally through the use of new and improved impact evaluations. In particular, there have been calls for evaluations that use quasi-experimental designs. Qualitative data can shed light on unforeseen impacts, and can also provide valuable insights into possible pathways for impacts. Assessments from both those delivering and those in receipt of the intervention may provide helpful contrasts in perceptions of the intervention and its impacts, and may also explain unexpected impacts or the distribution of impacts.

Thomson (2008) goes on to identify a number of issues which need to be taken into account when assessing the health impact of area-based investment:

- Use of theory: Evaluations should be designed to test a pre-specified theory mapping a mechanism or route to a measurable outcome.
- Reporting of data/methods: Improved transparency of evaluation methods and reported results would improve the utility of evaluation data.
- Individual or routine data: Routine data is inexpensive but is often limited in reporting changes at individual level.
- Small effect size: Detecting small health effects will require a large study population to detect significant changes at a population level.
- Recruitment of target population: Response rates in areas of deprivation are falling.

- Comparison areas: Use of a suitable comparison area is desirable but identification of an area with equal need but not selected for the investment is difficult.
- Defining exposure to intervention: Individuals within the target area will have widely varying levels of exposure to what are often multiple interventions.
- Time-scale: Timing of final outcome is unknown but may be many years after the intervention. Aside from resource implications and attrition, long-term follow-up may have an effect itself, and the passage of time introduces additional confounding factors. An alternative is to use proxy measures which can be measured within 2–3 years, e.g., socioeconomic determinants of health.
- Defining success: Slowing the rate of downward trends may be an important indicator of success, but this may be wrongly reported as a negative impact.

Transferability

Potential significantly policy learning on place based approaches are often thwarted by the dismissal of emergent policy findings as parochial (Halliday & Asthana 2005). These authors note that this denies the significance of place as a mediator of policy and the potential to transfer from the local to the national

Future Research Directions

The aim of this report was to review the literature on place-based understandings of health inequality as a first step in developing a program of research that investigates the relationship between health inequality and place in Tasmania. Our review of the literature shows that place does impact on health in a range of complex ways and that interventions and policies focused at an area level can play a positive role in improving health outcomes and reducing health inequalities. The vast majority of the literature reviewed in this report is based on international research. Of the Australian studies which were identified none focuses on role of 'place', as defined in the literature, on patterns of health and wellbeing in Tasmania. We believe, especially given the potentially significant impact of contextual variables, that there is a need to address this knowledge gap through systematic research into the role of place in determining health inequalities in Tasmanian and the value of place-based approaches for tackling health inequality.

We see opportunity for research that investigates:

- Whether place impacts upon health and health outcomes in Tasmania and if so to what extent;
- the characteristics of areas that have poorer health outcomes and characteristics of areas that have better health outcomes; and
- what factors appear to shape place-based health inequalities in Tasmania; for example, the relative importance of composition and context (the people who live there, the social, physical and environmental characteristics of the areas etc)?

To address these questions we propose a research agenda which progresses in two phases.

Phase 1: *A systematic assessment of place as a determinant of health inequality in the Tasmanian Context.*

The next phase of the research project will compile, aggregate and analyse existing data to evaluate the interplay between place and health outcomes in the Tasmanian context. There are a number of data sets which could be used to provide a quantitative overview of the geographic distribution of health inequality in Tasmanian. We acknowledge that there are limitations with the availability of Tasmanian data is some national data sets however, through a process of consolidating existing data we believe that it is possible to develop a robust picture of the relationship between place and health inequality within Tasmania.

Having developed a quantitative picture of the spatial distribution of health inequality in Tasmania we will conduct an audit of existing policies and programs assessing the extent to which they are informed by a place-based rationale, or their potential to be used as a platform for place-based initiatives. For example, the network of Community Houses in Tasmania is a resource which is amenable to the delivery of place based health strategies in disadvantaged communities. In terms of policies, the review will identify elements of the *Healthy Tasmania* strategy where we establish that target populations are geographically concentrated. This research aims to identify geographic clusters with poor health outcomes or behaviours targeted by *Healthy Tasmanian* which can be used as potential sites for detailed studies in Phase 2. Having identified potential sites for pilot place-based interventions Phase 1 will conclude with an overview of a research design aimed to establish

the complex contextual variables which may contribute to poor health outcomes at these sites of health disadvantage. These findings will be documented in a final report to be completed in July 2012 which will directly inform the design of the evaluation project which constitutes Phase 2 of the Project.

Phase 2: Designing and Evaluating Place Based Interventions to Address Health Inequality in Tasmania.

The aim of the research team is apply the findings from Phase 1 to design a research project which develops and evaluates place-based interventions designed to address health inequalities. This multi-year project will refine the mixed methods approaches for assessing the influence place on health outcomes identified in this report and apply them to an evaluation of existing *Healthy Tasmania* programs. Having established this benchmark the study will establish strategic pilot studies where program deliver is informed by best practice from a the perspective of the place based literature. These pilots will add a valuable comparative dimension to the analysis allowing the study to draw robust conclusions concerning the effectiveness of the place based approaches in the Tasmanian context. The project team aims to finalise an NHMRC funding application for this project by late 2012.

References

- Abel T. K, Frohlich (2012) 'Capitals and capabilities: Linking structure and agency to reduce health inequalities', *Social Science & Medicine* xxx (Article in press)
- Australian Social Inclusion Board (2011a) Breaking Cycles of Disadvantage <<http://www.socialinclusion.gov.au>>
- Australian Social Inclusion Board (2010^a) Social Inclusion in Australia: How Australia is Faring
- Australian Social Inclusion Board (2011^b) Governance Models for Location Based Initiatives
- Australian Bureau of Statistics (ABS) (2010) Health and Socio-economic Disadvantage, Australian Social Trends, March 2010, Cat. No. 4102.0, Canberra.
- Bauld, L., K. Judge, M. Barnes, M. Benzeval, M. Mackenzie & H.Sullivan (2005) 'Promoting social change: the experience of health action zones in England', *Journal of Social Policy*, 34 (3). pp. 427-445.
- Baum F. (2007) 'Cracking the Nut on Health Equity: Top Down and Bottom Pressure for Action On The Social Determinants of Health', *Promotion and Education*, 14: 2: XX-XX.
- Baum, F. & C. Palmer (2002) "Opportunity sturctures': urban landscape, social capital and health promotion', *Health Promotion International*, 14(4): 351-361.
- Bernard P., K. Charafeddine, K. Frohlich M. Daniel Y. Kestens L. Potvin (2007) 'Health inequalities and place: A theoretical conception of neighbourhood', *Social Science & Medicine*, 65:1839–1852.
- Blaxter, M. (1997) 'Whose fault is it? People's own conceptions of the reasons for health inequalities', *Social Science and Medicine*, 44(6): 747-756.
- Bradford N (2005) 'Place-based Public Policy: Towards a New Urban and Community Agenda for Canada', Research Report F|51Family Network, Canadian Policy Research Networks Inc.
- Chaix, B., M. Rosvall, J. Merlo (2007) 'Assessment of the magnitude of geographical variations and socioeconomic contextual effects on ischaemic heart disease mortality: a multilevel survival analysis of a large Swedish cohort', *Journal of Epidemiological Community Health*, 61: 349-355.
- Cummins, S., M. Stafford, S. Macintyre, M. Marmot, A. Ellaway (2004) 'Neighbourhood environment and its association with self rated health: evidence from Scotland and England', *Journal of Epidemiological Community Health*, 59: 207-213.
- Curtis, S. & I. Jones (1998) 'Is there a place for geography in the analysis of health inequality', *Sociology of Health & Illness*, 20(5): 645-672.
- Dahlgren G. & M. Whitehead (1991) 'Policies and strategies to promote social equity in health', Stockholm: Institute of Future Studies
- Dahlgren G and Whitehead M. (2006), 'European strategies for tackling social inequities in health: Levelling up Part 2' World Health Organization
- Davidson R., J. Kitzinger K. Hunt (2006) 'The wealthy get healthy, the poor get poorly? Lay perceptions of health inequalities', *Social Science & Medicine*, 62 (2006) 2171–2182

- Department of Health and Human Services (2009) Tasmanian Smoking Data November 2009, working document Population Health
- Department of Health and social Security (1980) *Inequalities in Health*, Report of a working group chaired by Sir Douglas Black, DHHS, London.
- Ecob, R. & S. Macintyre (2000) 'Small area variations in health related behaviours: do these depend on the behaviour itself, its measurement, or on personal characteristics?', *Health & Place*, 6:261-274.
- Ellaway A. & Macintyre S. (2009) 'Neighbourhoods and health' In: Brown T, McLafferty S, Moon G. (eds) *The Companion to Health and Medical Geography*. Oxford: Blackwell Publishing, pp.399-417
- Exworthy M. (2008) 'Policy to tackle the social determinants of health: using conceptual models to understand the policy processes', *Health Policy and Planning*, 23:318-327
- Feldman, P., D. Warr, T. Tacticos & M. Kelaher (2009) 'People, places and policies – trying to account for health inequalities in impoverished neighbourhoods' *Australian and New Zealand Journal of Public Health*, 33(1): 17-24.
- Franzini, L. & W. Spears (2003) 'Contributions of social context to inequalities in years of life lost to heart disease in Texas, USA', *Social Science and Medicine*, 57: 1847-1861.
- Friel S. M. Akerman, T. Hancock, J. Kumaresan, M. Marmot, T. Melin D. Vlahov (2011) 'Addressing the Social and Environmental Determinants of Urban Health Equity: Evidence for Action and a Research Agenda', *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 88(5): XX-XX.
- Frohlich, K., E. Corin & L. Potvin (2001) 'A theoretical proposal for the relationship between context and disease', *Sociology of Health & Illness*, 23(6):776-797.
- Gatrell, A., C. Thomas, S. Bennett, L. Bostock, J. Popay, G. Williams & S. Shahtahmasebi (2000) 'Understanding health inequalities: locating people in geographical and social spaces' in H. Graham (ed.) *Understanding Health Inequalities* Open University Press: Philadelphia, pp.XX-XX
- Graham, H. (2004) 'Social Determinants and Their Unequal Distribution: Clarifying Policy Understandings', *The Milbank Quarterly*, 82(1): 101-24.
- Halliday J. & S. Asthana (2005) 'Policy at the margins: developing community capacity in a rural Health Action Zone', *Area*, 37(2): 180-188.
- Hansen E.C. & G. Easthop (2007) *Lifestyle in Medicine*, Routledge: London.
- Judge K. & L. Bauld (2006) 'Learning from Policy Failure? Health Action Zones in England', *European Journal of Public Health*, 16(4):341-344.
- Kavanagh, A.M., J.L. Galler, T. King, D. Jolley, D. Crawford & G. Turrell (2005) 'Urban area disadvantage and physical activity: multilevel study in Melbourne, Australia', *Journal of Epidemiological Community Health*, 59: 934-940.
- King, T., A.M. Kavanagh, D. Jolley, G. Turrell, & D. Crawford (2006) 'Weight and place: a multilevel cross-sectional survey of area-level social disadvantage and overweight/obesity in Australia', *International Journal of Obesity*, 30: 281-287.

- Klein, H. (2004) 'Health inequality, social exclusion and neighbourhood renewal: Can place-based renewal improve the health of disadvantaged communities?'
- Larsen, K. (2007) 'The health impacts of place-based interventions in areas of concentrated disadvantage: A review of the literature', Sydney South West Area Health Service
- Macintyre, S., L. Macdonald & A. Ellaway (2008) 'Do poorer people have poorer access to local resources and facilities? The distribution of local resources by area deprivation in Glasgow, Scotland', *Social Science and Medicine*, 67: 900-914.
- Macintyre, S., S. MacIver & I. Sooman (2006) 'Area, Class and Health: Should we be Focusing on Places or People' in S. Nettleson & U. Gustafsson (eds.) (2006) *The Sociology of Health and Illness Reader*, Cambridge: Polity, pp. 278-292.
- Macintyre, S., L. McKay & A. Ellaway (2006b) 'Lay concepts of the relative importance of difference influences of health; are there major socio-demographic variations?', *Health Education Research* 21(5), pp.731-739.
- Macintyre, S. A. Ellaway, S. Cummins (2002) 'Place effects on health: how can we conceptualise, operationalise and measure them?', *Social Science & Medicine*, 55:125-139.
- Macintyre, S. (1997) 'What are spatial effects and how can we measure them?' in A. Dale (ed.) *Exploiting national survey data: the role of locality and spatial effects*, Faculty of Economic and Social Studies, University of Manchester, Manchester, pp.1-17.
- Macintyre, S. (2007) 'Inequalities in health in Scotland: what are they and what can we do about them?', Occasional Paper 17. Glasgow: MRC Social and Public Health Sciences Unit.
- Macintyre, S. (1997) 'The Black Report and Beyond: What are the issues?', *Social Science and Medicine*, 44(6),723-45.
- Mackenbach, J.P. (2005) 'Health Inequalities: Europe in Profile', UK Presidency of the EU.
- Mackenbach, J.P. (2011) 'The English strategy to reduce health inequalities', *The Lancet* – 377(9782): 1986-1988.
- Marmot, M.G. (2004) *Status Syndrome: How your Social Standing Directly Affects Your Health and Life Expectancy*, Bloomsbury, Oxford.
- Marmot, M.G., G. Rose, M. Shipley & P. J. Hamilton (1978) 'Employment grade and coronary heart disease in British civil servants', *Journal of Epidemiology and Community Health* 32, 244-9.
- Marmot, M.G, J. Siegrist, T. Theorell & A. Feeney (1999) 'Health and the Psychosocial Environment at Work' in M. Marmot and R.G. Wilkinson (eds) *Social Determinants of Health*, Oxford University Press, Oxford.
- Marmot, M.G. & Wilkinson, R (eds) *Social Determinants of Health*, 2nd edition, Oxford University Press: Oxford.
- Mathieson J, J. Popay, E. Enoch, S. Escorel, M. Hernandez, H. Johnston & L. Rispel (2008) 'Social Exclusion Meaning, measurement and experience and links to health inequalities; A review of literature', WHO Social Exclusion Knowledge Network Background Paper 1, WHO.
- McLaren L, P. Hawe (2005) 'Ecological perspectives in health research', *Journal of Epidemiological and Community Health*, 59:6-14.

- Melbourne Centre for Community Child Health (2011) 'Place-based approaches to supporting children and families', Policy Brief Issue 23, The Royal Children's Hospital, <<http://blogs.crikey.com.au/croakey/2011/12/22/place-based-approaches-to-supporting-children-and-families-what-are-they-and-why-do-they-matter/>>. (01 February 2011).
- National Health Strategy (1992) 'Enough to Make you Sick: How Income and Environment Affect Health', AGPS, Canberra.
- O'Dwyer, L. F. Baum, A. Kavanagh & C. MacDougall (2007) 'Do area-based interventions to reduce health inequalities work? A systematic review of evidence', *Critical Public Health*, December, 17(4): 317–335.
- Pickett, K.E. & M. Dorling (2010) 'Against the organization of misery? The Marmot Review of health inequalities', *Social Science & Medicine*, 71: XX-XX.
- Pickett, K.E. & M. Pearl (2001) 'Multilevel analyses of neighbourhood socioeconomic context and health outcomes: a critical review', *Journal of Epidemiological Community Health*, 55: 111-122.
- Pickin C., J. Popay, K. Staley, N. Bruce, C. Jones, & N. Gowman (2002) 'Developing a Model to Enhance the Capacity of Statutory Organisations to Engage with Lay Communities', *Journal of Health Services and Research Policy*, 7(1): XX-XX.
- Popay, J., C. Thomas, G. Williams, S. Bennett, A. Gatrell & L. Bostock (2003) 'A proper place to live: health inequalities, agency and the normative dimensions of space', *Social Science and Medicine*, 57: 55-69.
- Popay, J., G. Williams, C. Thomas & A. Gatrell (1998) 'Theorising inequalities in health: the place of lay knowledge', *Sociology of Health and Illness*, 20(5): 619-644.
- Thomson, H. (2008), 'A dose of realism for healthy urban policy: lessons from area-based initiatives in the UK', *Journal of Epidemiological and Community Health*, 62:932–936.
- Turrell, G., A. Kavanagh, G. Draper & S. Subramanian (2007) 'Do places affect the probability of death in Australia? A multilevel study of area-level disadvantage, individual-level socioeconomic position and all-cause mortality, 1998-2000', *Journal of Epidemiological Community Health*, 61: 13-19.
- Veenstra, G., I. Luginaah, S. Wakefield, S. Birch, J. Eyles & S. Elliot (2005) 'Who you know, where you live: social capital, neighbourhood and health', *Social Science and Medicine*, 60: 2799-2818.
- Wainwright, H (1994) . Arguments for a New Left: Answering the Free-Market Right. Oxford:
- Whitehead, M., Dahlgren G & Gilson L (2001) *Developing the policy response to inequities in Health: a global perspective. Challenging inequities in health care: from ethics to action*. New York: Oxford University Press.
- Wilkinson R.G. (1996) *Unhealthy Societies: The Afflictions of Inequality*, Routledge London
- Wilkinson, R.G. and Pickett, K. (2009) *The Spirit Level: Why Equality is Better For Everyone*, Allen Lane.
- Wood J, Hennell T, Jones A, Hooper J, Tocque K, Bellis M (2005) 'Where Wealth means Health: Illustrating Inequality in the North West', North West Public Health Observatory

- Woolcock, M (1998) 'Social Capital and Economic Development: Towards a Theoretical Synthesis and Policy Framework' *Theory and Society*, 27, 151-208.
- Ziersch, A. (2005) 'Health implications of access to social capital: findings from an Australian study', *Social Science and Medicine*, 61: 2119-2131.
- Ziersch, A., F. Baum, C. MacDougall, & C. Putland (2005) 'Neighbourhood life and social capital: the implications for health', *Social Science and Medicine*, 60: 71-86.