

# Cracking the nut of health equity: top down and bottom up pressure for action on the social determinants of health

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**Abstract:** The Commission on the Social Determinants of Health (CSDH) was established to advise on ways in which understanding of the social determinants of health can affect practical action to improve population health equitably. This paper considers the factors that are necessary to encourage governments to adopt policies that aim at doing this. It argues that knowledge, while essential, is insufficient. Governments need a commitment to the values of fairness and justice and an ability to cope with the complexity of responding to social determinants beyond exhorting individuals to change their behaviour. The role of civil society is crucial in advocating for governments to do this. The presence of linking social capital is also crucial to creating a social and political environment in which fairness is promoted. A case study of the poor health status of the Aboriginal peoples in Australia is used to illustrate the importance of social capital. (*Promotion & Education*, 2007, (2): pp 90-95)

Key words: social determinants of health, linking social capital, aboriginal health.

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When the late Dr. Lee, Director General of the World Health Organization, announced the formation of the Commission on the Social Determinants of Health (CSDH) at the World Health Assembly in May 2004 he commented:

*“The goal is not an academic exercise, but to marshal scientific evidence as a lever for policy change – aiming toward practical uptake among policymakers and stakeholders in countries”*

This paper focuses on factors that are likely to encourage and initiate practical action on the social determinants of health inequities. It will include discussion of the need for both evidence and knowledge together with understanding and a commitment to equity. Consideration will be given to the importance of the “nutcracker” effect which describes the power of the combination of top down and bottom up action on health equity. The arguments articulated herein demonstrate that societies, which focus on *linking social capital* (as defined by Szreter & Woolcock(2004) and discussed in detail below) are more likely to be committed to and effective in taking action on the social determinants of health than those with low levels of linking social capital.

## Powerful combination of evidence, knowledge, understanding and values

Knowledge and evidence are clearly important to achieving action on health equity. The CSDH has established a knowledge network on Evidence and Measurement. The first paper from this network (Kelly et al., 2006) argues strongly in favour of methodological pluralism and epistemological variability in approaches to studying the social determinants of health and health

inequity. They note “Humans use different forms of knowing and different forms of knowledge for different purposes. There is no necessary hierarchy of knowledge involved until we need to discriminate on the basis of fitness to purpose” (Kelly et al., 2006). An understanding of the complexity of factors that contribute to the social determinants requires an insight into many different disciplines and the use of a range of methods. However, the most useful qualitative research methodology involves interviews of key informants to ascertain ways in which social, economic and political structures shape individual experiences. For example longitudinal epidemiological studies that enable the determination of causal links between exposure to certain social and economic conditions and diseases or policy studies of the outcome of different systems of social welfare. Such knowledge is often context specific and contingent on political and economic circumstances. The complexities of this process and the broad range of knowledge on social determinants is often envisaged to be an impediment to the uptake of the knowledge in this area. Commenting on the challenge of getting knowledge to inform policy and practice, Speller (2001) used Stacey’s (1996) Agreement & Certainty Matrix demonstrate that health promotion and public health initiatives often fall into a zone of complexity that leads to uncertainty about what works and consequently to a lack of agreement among policy makers and practitioners. Stacey stresses the need for non-linear and creative thinking when organisations are working at the edges of chaos and dealing with complex information to obviate issues emerging from lack of consensus. It is envisaged that such situations often arise when organisations attempt to address the social determinants of health. Thus it will take a particu-

lar combination of commitment to justice, understanding of complexity and the ability to lead organisations through the change necessary to cope effectively with complexity in order to lead to the actions, which the Commission envisages lending impetus to.

Evidence on health inequities has been available in many developed countries for sometime; however, this has not ensured the institutionalization of remedial action. Most notably, the “Black Report” in the United Kingdom (Townsend & Davidson, 1992) was rejected by the incoming Thatcher Government despite the compelling information it presented on the existence of inequities and the possible reasons for their existence. This and many other examples show that while evidence on inequities is necessary it is certainly not sufficient to ensure action. Policy makers also need to know what can be done to reduce inequities and need to work from a values base that emphasises the pursuit of social justice as crucial to society. Knowing what is to be done requires coming to grips with the range of choices that lie inside and outside the health sector.

The international health promotion movement has come a long way in the past twenty years. In the 1970s and 1980s, behaviour change using pamphlets and marketing campaigns was the overriding tool of health promotion. Subsequently, the concept of health promotion was revolutionized by the Ottawa Charter for Health Promotion (WHO, 1986), which established that while changing behaviours was indeed a crucial aim of health promotion, bringing change at that level involved a complex interplay of policy and strategy, creating supportive environments, encouraging community action and reorienting health services. The Ottawa Charter was instrumental in galva-

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nizing action in many countries. In Australia, for example, impact at the population level was clearly evident and manifested itself as reduction in prevalence of smoking and smoking related morbidity, decrease in road accident-related fatalities, reduction in suicide rate and decline in the rate of skin cancer (Baum, 2002). Each of these has been achieved not through single measures but through a battery of self reinforcing measures. While these are significant public health gains, they have done little to address inequities and reduce the existing gradients. Here it is important to recognize that unless designed with a very strong equity lens, health promotion can act to increase the difference between groups rather than reduce them even if they improve population health as a whole. For example, there is evidence that people in higher socio-economic groups are more likely to be successful in quitting smoking (Osler & Prescott, 1998; Barbeau, Krieger, Soobader, 2004). In Australia over the period 1998-2004, while there has been a 9% decline in smoking among the lowest quintile, the rate of change for the highest socio-economic quintile is 35% (see Table 1). A reasonable conclusion is that anti-smoking messages have been more successful with better off people and, at least temporarily, have increased inequality.

Further complicating our message is the fact that health inequities do not reflect a dichotomy between a disadvantaged group at the bottom of the social advantage pile and the rest sharing equal health status. The work of Sir Michael Marmot (Chair of the Commission on the Social Determinants of Health) and colleagues (see summary in Marmot, 2004) has shown that the distribution of health in communities is in the form of a gradient. This gradient is also illustrated in Table 1 where the percentage decline in smoking across socio-economic quintiles is in the form of a gradient from high to low. This has great significance for the strategies we adopt to bring about equity. The gradient in health suggests that we need population wide universalist strategies as well as those targeted at the most disadvantaged. Again this is a more complex argument to advocate to policy makers than the one which

focuses on the need to target those at the bottom of the pile.

Taking action on the social determinants of health to reduce health inequity will also require politicians and policy makers to resist what Kickbusch (2006) has called "the doability of medicine". Modern medicine offers individuals considerable possibilities. But many of its interventions will not have a discernable impact on population health (as opposed to the health of a few individuals, usually towards the end of their life). Perhaps this is the hardest lesson for policy makers and politicians to grasp. Yet it is also the most important lesson to grasp if we are to have the understanding necessary to bring about a real determination to improve health across populations. Rose (1985) has set this lesson out most clearly. He points out that treating high risk or diseased individuals does not have much impact on population health levels overall, but changing a risk factor across a whole population by just a small (and often clinically insignificant) amount can have a great impact on the incidence of a disease or problem in the community. For example reducing salt intake in manufactured food by a small proportion across a population (at a level individuals would not notice) would reduce blood pressure levels and in time reduce death rates from cardiovascular disease. Add to this the need to implement population-wide strategies in a way that is equitable and the extent of complexity of knowledge and concepts is considerable. Rose's message about population health is counter intuitive and the difficulties of grasping it effectively is, in all likelihood, the reason why we face challenges in shifting our health care system to a focus on prevention, health promotion and social determinants of health, despite so many WHO and Government sponsored reports that have called for this reorientation (Benezeval, 2003; Independent Inquiry into Inequalities in Health, 1998; Stahl et al., 2006; Stegeman & Costongs, 2003; WHO, 1978; WHO, 1986; Wilkinson & Marmot, 2003).

Understanding of Rose's dictums on preventive medicine are likely to be heeded more easily in those who have a more collective mind set rather than those more

committed to a strong individualism. This fact was pointed out by Tesh (1988) when she pointed to the strong individualism that underpins public health policy in the United States. A strong ethos of individualism is likely to lead to victim blaming assumptions (Crawford, 1977). Such an attitude is obvious in the following comment by an Australian federal health minister, Tony Abbott (2005) on a television program on childhood obesity:

*"No-one is in charge of what goes into my mouth except me. No one is in charge of what goes into kid's mouths except their parents. It is up to parents more than anyone else to take this matter in hand... if their parents are foolish enough to feed their kids on a diet of Coca Cola and lollies well they should lift their game and lift it urgently"*.

Tesh (1988) points out that the very research questions we ask are shaped by core values. Thus a focus on individualism would lead to questions about why individuals are over weight and explore their motivations while a more collective ideology would explore questions about why it is that obesity levels in all high income countries have increased in the past decade and consider what features of the society have encouraged this. The assumption that changing behaviour is about personal motivation is very common despite the evidence that people need supportive environments in which to make healthy choices and that pressures from social mores, advertising and constraints of health food availability are likely to have strong influences on the choices people are able to make (Baum, 2002). There are many factors that reinforce ideologies of individualism. These include the fact the ideology is less threatening to many vested interests, especially commercial interests, the philosophy of some political parties are grounded in a strong belief in the individual rights even when these are at the expense of the common good and the fact that protecting the rights of individuals has often been a guard against the excesses of totalitarian regimes. Consequently public health is often viewed as being aligned with a 'nanny state' that seeks extreme measures that restrict rights. This view has been voiced during campaigns to introduce tobacco control, enforce seat belt legislation, restrict the ownership of firearms, restrict the advertising of junk food and enforce sun protection in schools.

The fact that many of the determinants of health of health lay outside the formal health sector also complicates the tasks of implementing action on the social determinants of health. In the past twenty years the importance of cross sectoral action has

**Table 1. Percentage smoking and percentage change by five socio-economic quintiles in Australia, 1998-2004**

	1998	2001	2004	% Change
1st Lowest	30.0	25.8	27.3	-9%
2nd	27.0	25.1	23.6	-13%
3rd	28.4	23.7	21.7	-16%
4th	25.8	23.6	18.2	-29%
5th Highest	23.1	18.4	15.1	-35%

Source: Data derived from Adhiknit and Summerhill, 2000; Australian Institute of Health and Welfare 2002 & 2005.

Figure 1: **The nutcracker effect: top down and bottom up action for health equity**



been repeatedly reinforced and put into practice. Through the Healthy Cities projects, the need to integrate government initiatives in the intersectoral domains was demonstrated, particularly with reference to road injuries, substance abuse, and poverty (Ashton, 1992; Baum 2002; WHO, 2007). European Union’s current focus on ‘Health in All Policies’ is testimony to the acceptance of this message (Stahl et al, 2006). The crucial task now remains to ensure that this intersectoral action happens effectively and as a matter of course and is implemented with a strong focus on reducing equity.

The messages of modern health promotion then are complex. They involve understanding the factors that impact on population and the existence of a health gradient, the limitations of most medical therapy as a means to make significant

improvement to population health, and understanding that while behaviour change is the aim of health promotion, achieving this effectively is not about simply telling people to do so, but in creating supportive environments which will require action from multiple agencies. The task of equity health promoters would be much easier if there were a simple message to pitch to politicians and senior policy makers. But the reality of the situation makes equity a hard nut to crack. The following section considers the social and political environments in which equity is more likely to make it to the policy agenda.

### The “nutcracker” effect

The “nutcracker” effect is illustrated in Figure 1. It demonstrates the value of combining top down political commitment and policy action with bottom up action from

communities and civil society groups. Government commitment to taking action on the social determinants of health equity is likely to result from a belief in social justice and an understanding of the complexities of health promotion as detailed in the previous section. If a government reflects a political commitment to individualism and is wary of an overly interventionist ‘nanny state’ then the pursuit of equity is unlikely to be on its social policy agenda to any extent. In this situation it will be hard to find much pressure exerted on the top of the lever. Such was clearly the case in Thatcher’s Britain. Action on health equity only resulted when Blair Labour Government was elected on a platform that included a strong commitment to pursuing equity. By contrast, a government driven by a belief in social justice is likely to implement policies designed to reduce inequities; the Nordic welfare states have provided a strong example of such governments. A powerful influence on government’s desire to be socially just is the pressure from the more socio-economically better off in a society to do so. The existence of this pressure has been described as linking social capital and is described in more detail below. The other crucial part of the nutcrackers effect is the bottom up action from civil society.

### Civil society action

One way in which governments can be persuaded to take action is through bottom up pressure. This is a consequence of growing inequities as a result of which communities prefer governments who state a commitment to reduce such inequities. Within this context, history provides numerous examples of the role of civil society in bringing about change. Outstanding examples are the suffragettes in ensuring votes for women; the civil rights movement in the USA in stopping sanctioned segregation; and the anti-apartheid movement in bringing democracy to South Africa; and the green movement in putting environmental issues on national and international agendas and the land rights movement in Australia. (See Burgmann, 2003, for a discussion of these various social change movements). In each case, years of grass roots actions led to irresistible pressures for change. In recognition of the important role that the civil society may play in arguing for action on the social and economic determinants of health the Commission on the Social Determinants of Health has established a stream of work on the role of civil society which has involved many civil society players. The report from the June 2006 meeting of the Commission (Commission on the Social Determinants of Health, 2006)

notes that the Commissioners recognised the distinctive contribution of civil society in country level action on the social determinants of health including direct engagement with national governments and national commissions on social determinants such as those in Kenya and Brazil. They also noted the importance of mass mobilization such as the Indian People's Health Assembly and the crucial role of labour organisations and trade unions (Commission on the Social Determinants of Health, 2006, p. 22). Civil society groups may also play a major role as advocates of equity. Globally the People's Health Movement (PHM) has played such a role since its formation at the first People's Health Assembly. The movement has organized two People's Health Assemblies to date (intended as alternative World Health Assemblies) from which two key documents have emerged – the Peoples' Health Charter written in 2000 and the Cuenca Declaration (2005) (see PHM, 2006, for copies) have made powerful statements about the need to reduce global inequities. Many health promotion and public health associations around the world make similar calls. Locally community-based health promoters also play crucial advocacy roles for health equity. It can therefore be argued that collectively, civil society is crucial to bring the bottom up political pressure to bear on politicians and policy makers so that they are willing to take action on health equity. Civil society can be oppositional to governments and in extreme situations can bring about social and political change by contributing pressure for a change of government. In other situations, progressive civil society can work through advocacy and incremental change and will be opportunistic about chances to influence policy agenda.

### Linking social capital

So far we have seen that bringing about action on health equity will reflect a complex mix of sufficient evidence, good understanding of what changes population health, a political elite committed to changes and active civil society pressure for that change. But we are still left with the question of how is it that some societies are more inclined towards taking action to reduce health inequities than others. Some clues can be found in the notion of linking social capital. Szreter & Woolcock (2004, p.655) define linking social capital as “norms of respect and networks of trusting relationships between people who are interacting across explicit, formal or institutionalised power or authority gradients in society.” What does this mean in practice? A society high in linking social capital is

likely to be characterised by the following features:

- High trust in formal institutions.
- Fair and transparent public policy processes.
- Commitment to redistribution by the better off people in society.
- Commitment to activities of State (e.g. low taxation evasion).
- Opportunities for people from different groups to interact in a respectful manner.

There are indications that many of these factors are declining rather than increasing. Trust in institutions has declined significantly in the past two decades in most countries where this is measured (Eckersley, 2004). While transparency and fairness are upheld as hallmarks of democracy in practice there have been significant challenges to this. The extent of commitment to redistribution varies around the world from the Nordic countries, where it is high, to others where taxation policy is moving away from redistribution, Australia and the US included (Stretton, 2005). Many corporations and very rich individuals seek to avoid tax and show little commitment to the country in which they operate, preferring to avoid tax whenever possible (Korten, 2006). A society high in linking social capital would have its richest corporate and individual citizens committed to supporting a strong taxation base. This base would make possible redistributive measures. In the Australian context, Stretton (2005) has pointed out that under the conservative Menzies government in the 1950s the top margin tax rate was far higher than it is in Australia today. Finally, what opportunities are there for people to interact respectively across class and ethnic difference? The degree to which this can happen varies from society to society but in societies marked by considerable inequity it happens less. The consequence is that there are less common bonds and less understanding. Linking social capital implies that there is a sense of obligation from powerful institutions in society towards the less powerful. Bourdieu's (1986) conception of social capital makes it clear that the networks and reciprocities involved in exchanges most commonly work to the benefit of the already well-off and more powerful groups. They do this by giving people pathways by which they gain access to educational, cultural and employment opportunities. Policies aimed at reducing inequities should, as an aim, work towards ensuring that benefits that accrue to certain classes in society are made available to other less powerful and privileged groups as well, on the premise that a society that supports and encourages such policies is

likely to be characterised by high linking social capital. The importance of this notion of linking social capital is best illustrated by a case example articulated herein, which focuses on a case study of the absence of linking social capital between Australian Aboriginal and non-Aboriginal peoples. The case shows how the absence of linking social capital can have profound impact on health and illustrates how the presence of strong linking social capital has the potential to encourage government commitment to equity.

### Australian case study of the lack of linking social capital

The case of the relationship between non-Indigenous Australians and Indigenous Australians illustrates the importance of the concept of linking social capital to the likelihood of effective intervention to reduce health inequity. Indigenous people in Australia have been described as second class citizens in Australia (Chesterman & Gilligan, 1997). In the early days of settlement there is solid evidence (Hunter 1993; Reynolds 1998) that they were subjected to considerable violence. In the 20<sup>th</sup> century much Indigenous experience was shaped by the welfare policies purported to be in the best interests of Indigenous people. In fact, it controlled their lives to the extent that children were removed from their families and the law dictated who Indigenous people could and could not marry. The experience of the “stolen generation” has been well-documented in the Bringing Them Back Home Report (Human Rights and Equal Opportunity Commission 1997). It demonstrates the significant impact that these experiences have had on the health and well-being of the Indigenous people caught up in this shameful period of Australian history. Clearly one of the sequelae of these experiences is a legacy of deep mistrust that the Indigenous people have towards mainstream institutions of the non-Indigenous society, such as, the police, health and welfare systems, and schools. Clearly, very little linking social capital was evident in this area.

Non-Indigenous Australians often project negative views of Indigenous Australians that reflect purely on their current behaviour and situation without taking into account the impact of the historical experience of Indigenous peoples. Indigenous peoples are far more excluded from the social and economic mainstream of Australian life than are other Australians (Trudgen, 2000). They are also subjected to significant racism (Hunter, 1993) and live in a world which is dominated by invisible and largely unacknowledged assumptions of whiteness (for further details of concept of

'whiteness' see Riggs 2004; Fein et al., 1997). The history of Australia since the invasion by white people shows that a number of factors have worked to determine the health of the indigenous people; these include: the way society has been organized, the degree and nature of interaction between Indigenous and other Australians, the levels of trust between the two groups and the extent of care extended to Indigenous Australians by the wider society. Limited attempts have been made to bridging the social capital between Indigenous and non Indigenous Australians and therefore the scope for linking social capital to development has sadly been lacking in Australian society. This has led to the exclusion of the Australian Indigenous people from mainstream economic, educational and social life in Australia. Some insights into the likely impact of social exclusion on health can be gained from the recent literature debating the impact of income inequality across populations. Wilkinson (2005) has argued that a key determinant of population health outcomes is the extent to which societies distributed their income equally with more equal societies achieving higher population health outcomes. He theorised that part of the explanation for this pattern was that countries with less equal distribution of income also had lower levels of social capital. He argues that this link exists because unequal societies are characterized by individuals with increased anxiety and low social support institutions and by higher levels of violence and disrespect between citizens. His work has been strongly criticized for underplaying the role of access to material factors (especially employment and housing) that underpin inequalities (see for example, Lynch et al., 2000). However it gains support from the work of Michael Marmot and colleagues (Marmot et al., 1991; Brunner & Marmot, 1999) who explain health status gradients in populations through the stress people experience from not being at the top of hierarchies and the consequent absence or loss of autonomy over one's life, working and neighbourhood environment. Applied to the experiences in the Australian context, it is evident that racism and economic inequity have led to lack of control on part of the indigenous people, over their life in terms of its direction, culture and traditional ways and the ownership of land. This has led to extreme stress for Indigenous peoples; Marmot's work indicates that it is likely to have a very significant impact on health. The situation principally results from the lack of supportive policies from mainstream Australia – the lack of linking social capital. Szreter and Woolcock (2004) argue that consideration of the relationship of the state in terms of the initiation and sus-

taining of networks, trust and social structures is crucial. They show, with illustrations from a case study from nineteenth century England, that states (local and central) can create and encourage the conditions in which linking social capital can operate. They can do this by ensuring that resources flow from more powerful to less powerful groups. Szreter and Woolcock's (2004) argument leads to the conclusion that greater linking social capital in Australia can lead to increased empathy about the dispossession suffered by Aboriginal people, and increase in the level of concern with respect to improving the material conditions and facilities and services available to Aboriginal people; this will contribute to advancing the common commitment to a goal of a society of mutually respecting citizens. While there have always been accounts of some sympathy and empathy and desire to link with Indigenous peoples from those more powerful, this has rarely been from other than a small minority (Reynolds, 1998).

Theories on linking social capital suggest that it is most evident at times when networks and trust develop between groups. Over the last fifty years, the Australian history does suggest that there has been a growing movement in which Indigenous peoples in Australia have been able to assert their rights more than in the past (Burgmann, 1993). Their endeavours have been supported by non-Indigenous people as was seen in the referendum on constitutional rights for Indigenous peoples and during the reconciliation marches of 2000. The early 1990s held promise of being a period in which linking social capital between Indigenous and non-Indigenous Australians might take root, as evidenced by the then Australian Prime Minister Paul Keating's 1993 Redfern speech:

*"And, as I say, the starting point might be to recognise that the problem starts with us non-Aboriginal Australians. It begins, I think, with the act of recognition. Recognition that it was we who did the dispossession. We took the traditional lands and smashed the traditional way of life. We brought the disasters. The alcohol. We committed the murders. We took the children from their mothers. We practised discrimination and exclusion. It was our ignorance and our prejudice. And our failure to imagine these things being done to us. With some noble exceptions, we failed to make the most basic human response and enter into their hearts and minds. We failed to ask - how would I feel if this were done to me?"*

This political will received strong support from an active reconciliation movement that reached a height with a reconciliation walk involving 250,000 Australians

across Sydney Harbour Bridge in May 2000. But recent events with the promotion of more punitive policies suggest any linking social capital has been on the decline in recent years. Recent policy directions such as the imposition of "Shared Responsibility Agreements" which demand certain behaviours from Indigenous people as a condition for receiving social security benefits have acted to reduce the autonomy of Indigenous peoples and have been interpreted as a return to more paternalistic policy days (Collard et al., 2005; Anderson, 2006). Our knowledge of the importance of *control to health status* (Marmot, 2004) suggests that policies should aim to encourage self-determination supported by resources that can make a difference. Linking social capital suggests a policy approach, which is trustful of communities, encourages them to do the right thing for their children and provides them with the infrastructure to create a health promoting environment.

## Conclusion

This article has examined the factors that are important for encouraging practical action on social and economic factors that affect population health and health inequities. It has argued that knowledge is crucial but insufficient and that in order to crack the nut of inequity, practical action is needed both from governments as well as the civil society. Civil society is constituted by a rich array of groups, many of whom remain concerned about promoting justice at a local level and lobby and advocate for equity-oriented policies. Their actions can encourage governments to take action and can develop popular constituencies to support action initiated by the government. Governments need to recognize that taking effective action would be reflective of their commitment to equity and justice and will enable them to deal with the complexity of evidence and devising complex responses. These responses need to be based on strategies that go beyond blaming individuals to those that focus on creating health and equity promoting environments. However, the exact process by which such commitment comes about differs from one context to another. Notwithstanding, it is likely to emanate from a society in which governments and their agencies have both the ability to deal with complex evidence and devise solutions that deal with this complexity leveraging social capital. This form of social capital ensures that the better off in a society are prepared to support and encourage action to improve the health in a way that reduces inequity. Thus when the Commission on the Social Determinants of Health reports in May 2008 a crucial legacy will include improved knowledge on how

action on social and economic determinants can be used by governments to improve population health equitably; examples of governments who are successfully taking such action; a strengthened civil society with a louder voice about the importance of this action and improved understanding of the processes (such as linking social capital) by which societies adopt fairness and justice as the basis of their social and health policies.

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