



Health Promotion Through an Equity Lens

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Health Promotion through an Equity Lens: Approaches, Problems and Solutions

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Introduction

The issue of disparities in health has become an important focus of health and public policy in recent years. The health equity gap is growing in all societies, particularly in relation to chronic and non-infectious diseases, and our continued reliance in dealing with these issues via traditional clinical, curative-based health care is being questioned (Irwin et al, 2006). Further, it has been argued that traditional health care access and delivery tend to favour the better off, and can amplify health inequalities (Taylor and Marandi, 2008).

Health promotion is defined by the WHO as the process of enabling people to increase control over and to improve their health (WHO, 1986, 1998). In theory, in terms of reducing inequity, health promotion programs aim to reduce inequality through empowerment — at the individual and community levels (Ridde, 2007). Further, health promotion programs aim to enable people to increase control over the determinants of their health — and this is not just done at the individual level, but also acknowledges that the society and environment we exist in influence our determinants of health (WHO, 1998). This conceptualization of health promotion allows us to see the importance and influence that health promotion programs can have in a discussion on health equity. The WHO (1998) says that inequalities in health occur as a consequence of differences in opportunities. It is thought — and hoped — that implementation of health promotion programs can alleviate some of these differences.

However, health promotion programs are not typically designed with a strong equity lens, and do not always take into consideration the unique concerns of those in disadvantaged groups (Baum, 2007). Of further concern is the issue that health promotion pro-

grams still tend to focus on individual-level behaviours, rather than taking into account social structures that allow these behaviours to exist (Low and Theriault, 2008). There is growing evidence that socioeconomic inequalities in health persist despite broad effort by health promotion programs to decrease the health gap (Graham 2009; Williams et al, 2008). A theory that has gained support in the health promotion community is that because the wealthy in society have more resources at their disposal, they are better able to follow the advice and/or therapies offered in health promotion programs (see Phelan and Link, 2005), and are in a better position to take up the opportunities provided (Mechanic, 2005).

A further issue is that the poor tend to wield little political influence, which puts them at risk for becoming further distanced from the policy makers who are in the best position to help narrow the health gap (Hodge, 2005). Because of this, it is particularly important that policy makers and health care professionals who are concerned with reducing health inequalities in society are aware of the unique issues related to health in more disadvantaged communities when formulating health promotion programs.

This paper will provide a broad overview of the main approaches to universal health promotion campaigns and programs — individual focussed and structural. It will then examine the advantages and disadvantages of both approaches, with special consideration paid to their effects on health inequalities. The paper will also examine some of the problems related to health promotion and equity, including the role of theoretical frameworks and political ideology in creating health promotion programs and policies, and will examine the role of evaluation and evidence. The paper will

conclude with recommendations about best practice in relation to health promotion activities that seek to close the health inequality gap.

Approaches to Health Promotion

This section of the paper will examine the different approaches to health promotion programs, while exploring the difficult issue of equity in such programs. It will examine both the agentic and structural approaches, and will identify the best model for health promotion programs seeking to reduce the health inequity gap.

AGENTIC VERSUS STRUCTURAL APPROACHES TO HEALTH PROMOTION

Broadly speaking, modern public health divides health promotion approaches into two categories – agentic and structural. Agentic programs are targeted at individuals, and generally require voluntary compliance. Structural approaches seek changes to the broader social context. A good example of the former is a screening program, and an example of the structural approach is the introduction of wide-spread smoking bans. Both approaches have their place in universal health promotion programs, but to determine which is most appropriate depends on the desired outcome and social context. The question in terms of health inequities is which approach will best reduce inequalities.

A further question is whether universal health promotion programs are the best approach to reducing inequalities in health. Because, by their very nature, they are meant to target the whole population, they raise two concerns. First, there is concern that they will not be taken up by the individuals most at risk and will therefore widen the inequity gap. Second, some observers are concerned that universal health promotion programs might actually lead to a ‘flattening up’ of inequities — if they are taken up uniformly across a population, they could improve overall population health, but without necessarily reducing the gap (Krieger et al, 2008).

If we are interested in designing and carrying out health promotion programs to reduce inequities in society, it is argued that we need to implement programs that take into account how social and other structural factors shape lifestyle choices (Low and Theriault, 2008). This, therefore, points to a strong need to employ structural health promotion programs that target the environment that people exist in. Modifiable risk factors for disease — like smoking or poor diet — are still often seen as an individual lifestyle choice, but such

choices are attributable to the social conditions we live and work in (Irwin et al, 2006). Agentic approaches to health promotion programs focus on individual-level behaviour. They alone don’t target the underlying factors that lead to the behaviour. Focus on individual risk factors and behaviour can neglect the social context that leads to such behaviour (Ostlin et al, 2005).

POSSIBLE SOLUTION: STRUCTURAL APPROACH TO HEALTH PROMOTION

There is increasing evidence that, if the main goal of a health promotion program is to reduce health disparities, a structural approach is the most appropriate way of ensuring that the health gap between more affluent members of populations and the more vulnerable does not widen. Structural approaches actually target the upstream drivers of health, rather than just focusing on individual-level behaviours (McGinnis et al, 2002). This is particularly relevant when the target disease or risk factor is more prevalent in disadvantaged communities, as is the case with conditions associated with smoking.

A 2007 review of tobacco control policies in Western Europe found that advertising bans, smoking bans, removal of barriers to smoking cessation products and other structural health promotion approaches had a greater potential to reduce the socioeconomic disparities associated with smoking than individual education and cessation programs (Giskes et al, 2007). Further, Bauld and colleagues (2007) found that while NHS Stop Smoking Services have had some impact on reducing health inequalities in relation to smoking, their agentic approach to smoking cessation has not had enough of an impact on disadvantaged populations in the UK. They therefore recommended that the UK government take further action to ensure that other structural policies — such as the recent smoking ban — are rolled out to work in tandem with the national Stop Smoking Services.

STRUCTURAL CHANGES AND EQUITY-TARGETED PROGRAMS

Health promotion programs are concerned with preventing disease. Many people in the health promotion field are particularly interested in using programs to target behaviour that is modifiable, and many of these behaviours that put one at risk for disease — such as smoking — are more prevalent in disadvantaged communities (Irwin et al, 2006; Wilkinson and Pickett, 2009). However, in terms of equity, these behaviours are not

just seen as individual choices, but are also viewed as a reflection of the environments that people exist in (Irwin et al, 2006). Structural approaches to dealing with this problem — like smoking bans — do, therefore, target these populations more, because there are more people in that sub-population who are more at risk for this behaviour. However, universal agentic programs — like smoking cessation clinics — are voluntary and require individual compliance, and people from disadvantaged groups are less likely to seek out these programs (Nettle, 2010). There are still questions as to why this is, but increasingly, the evidence shows that even when traditional barriers to access are reduced, people from disadvantaged backgrounds do not take up traditionally designed universal agentic health promotion programs as readily. (Baum, 2007).

Agentic health promotion programs also further reinforce a belief that a person's health status is entirely under the control of that individual, and without complimentary structural programs, imply that there is no collective responsibility for the determinants of health (Low and Theiraault, 2008). Further, there is increasing evidence that the inequalities in risk factors for disease can grow when programs only seek individual-level behavioural change, such as national health promotion campaigns and behavioural change programs, as they do not directly work on population exposure, and therefore do not address the risk of future cohorts (Capewell et al, 2010).

Therefore, it could be argued that the best way to ensure that all groups are reached is to apply structural universal health programs in tandem with targeted agentic programs, particularly programs targeted at health issues that are more prevalent in lower socioeconomic groups (see Baum, 2007). McLaren and colleagues defend this mixed approach (2010).

A comparative study of two programs in the UK to screen adults for cardiovascular disease risk found that a program in Scotland which targeted deprived areas would produce most of the benefit of a universal screening program carried out in England, but at a much lower cost (Lawson et al, 2009). A 2008 examination of US diet after folic acid fortification in 1998 found that despite absolute gains in folate levels, the lowest income groups had a higher relative ratio of low folate status compared with higher income groups – demonstrating that even a nation-wide structural intervention would still potentially require the targeting of specific groups to reduce inequalities (Dowd and Aiello, 2008).

Capewell and colleagues (2010) argue that these sorts of programs and interventions tailored at high-

risk groups might produce more noticeable benefits in terms of decreasing inequalities. The development of Healthy Living Centres in Scotland could be seen as a targeted, structural program to reduce disparities in the country (Rankin et al, 2009). These centres were created in 1999 through UK Lottery funding, and their nine overall priorities all focus on reducing health inequalities in disadvantaged communities. Centres and programs like these that are designed with a community empowerment framework allow for us to design and implement programs which have the root causes of disadvantage as their main consideration. In order to reduce the inequality experienced in most western societies between the rich and the poor, it is necessary that we take the unique needs of the disadvantaged into consideration when designing programs that aim to reduce inequality. Further, it is argued that by concurrently dealing with the structure and environment that enables the perpetuation of disadvantage, we can also make steps to eradicate the situation that is causing the health inequalities to exist in the first place (Nettle, 2010).

IMPROVING POPULATION HEALTH VERSUS DECREASING THE HEALTH GAP. CAN WE DO BOTH?

The fundamental question of whether universal health promotion programs widen the inequality gap remains. There is some evidence that the initiatives likely to have the greatest impact on improving overall population health might actually further widen the disparities between different subgroups, as the disadvantaged are likely to experience the least improvement (Williams et al, 2008). If our concern is reducing health inequalities rather than merely improving the health of the population as a whole, it is important to consider how these programs are structured. It is also important to keep in mind that even though the relative inequalities might remain after a universal health promotion intervention or program, we might be able to use such programs to reduce the absolute mortality and morbidity gap that exists between the rich and poor in society (Capewell et al, 2010). What is important is that these universal programs are used in concert with other, targeted programs that do attempt to eradicate the upstream drivers of disadvantage.

The Problems of Health Promotion and Equity

The next section will look at some of the issues that arise in relation to the development of health promotion programs with an equity focus, including the persistent biomedical focus in public health, the cost-effectiveness of health promotion programs, the problem of evidence in health promotion, and finally, the role of ideology in developing health promotion programs.

HEALTH PROMOTION AND THE BIOMEDICAL FRAMEWORK

One of the key roadblocks to health equity is the theoretical framework that underpins health promotion programs. The desired outcome of health promotion programs tends to be focused on improving the health of entire populations. Without an equity focus built into their design, issues related to decreasing health inequalities could be overlooked or ignored. In many countries, including Canada, population health is still viewed within a biomedical framework, and this can lead to reliance on medical results and epidemiological indicators without taking into account values, equity or social change (Cohen, 2006). The biomedical framework does not take issues of equity into account when studies are designed, carried out and evaluated. This is problematic for health promotion, because such a framework tends to emphasize programs that focus on the individual level behaviour which leads to disease, rather than examining the societal structure that leads to behaviour and shapes exposure to many risk factors. This framework leads programs to be agentic rather than structural.

However, when such population health programs are looked at through an equity lens, we are left with the problem that what improves the health of the whole population, doesn't necessarily improve the health of vulnerable or disadvantaged populations. For example, in the UK, the National Health Service (NHS) offers breast cancer screening programs – but those who take up the screening are disproportionately from more affluent areas (Capewell et al, 2010). If our desired goal is to target these disadvantaged groups in greater numbers, health promotion programs need to take the unique needs of these groups into consideration when designing programs, and this means they also need to pay attention to the theoretical framework behind the delivery of health promotion programs. Further, if

nations have a purely biomedical focus in their population health programs, the equity issue might not neatly fit into their more traditional model, because the problems related to equity are more structural in nature rather than solely relying on biomedical metrics. This issue of differing theoretical frameworks — and how society and policy makers view the role of health promotion in society — is important to come to terms with when considering how to tackle health inequalities.

COST-EFFECTIVENESS OF HEALTH PROMOTION PROGRAMS

Of key interest to policy makers is the cost-effectiveness of interventions. Health promotion programs tend to focus on preventing disease, while clinical medicine focuses on managing, treating, and curing disease. It is difficult to demonstrate that a disease has been prevented, but much easier to show that a disease has been managed, treated or even cured (McGinnis et al, 2002). This burden of proof issue is a greater problem for structural health promotion programs

Structural interventions are notoriously difficult to measure, because they don't simply target one behaviour, but rather the broader environment. However, a recent study in Australia stated that programs to encourage the reduction of salt in processed foods were highly recommended for improving population health and to reduce long-term spending in relation to cardiovascular disease and other risk factors, when compared to more agentic approaches, like dietary advice to individuals (Cobiac et al, 2010). This particular study did not specifically look at the implications of such a policy on reducing health inequalities, but because individuals from lower socioeconomic groups tend to have diets higher in processed foods, the benefit of salt reduction in processed foods would likely be found in these groups. It is argued that eliminating — or at least reducing — the structural elements that cause disadvantage and lead to poor health outcomes could reduce health-related economic costs in the long term. But, if health promotion is not operating in a theoretical framework that allows for such long-term goals — rather than just aiming to reduce incidence of disease in the short term — the cost effectiveness of such structural approaches could be overshadowed by agentic approaches that may show quicker results. This points to a need for suitable metrics and tools to account for the long-term and lasting benefit of structural changes.

THE PROBLEM OF EVIDENCE IN HEALTH PROMOTION

When dealing with health promotion programs, it is necessary to also consider evidence and evaluation. Evidence is considered necessary to reduce uncertainty in decision making, and traditional evidence-based medicine uses epidemiological methods to determine best practice (Raphael, 2000). It also seeks to determine a cause-and-effect relationship between a behaviour and an outcome. However, this methodology is problematic in health promotion. Health promotion differs from research done on health outcomes in that it usually seeks to modify behaviour before it becomes problematic, and therefore it can be difficult to demonstrate the cause-and-effect relationship. Further, structural approaches do not just target a single behaviour, but rather a collection of behaviours based on circumstances. Traditional quantitative models of health are not necessarily relevant for this type of health promotion research and evaluation, (Raphael, 2000). Ogilvie and colleagues (2005) argue that a strict adherence to the traditional hierarchy of study design for equity-based health promotion programs leads to knowing little about the programs and interventions that are most likely to influence the health of populations.

Health promotion evaluation needs to be able to take account of evidence outside of statistical data, such as more nuanced qualitative and ethnographic data, including human experience and values (Raphael, 2000). Indicators and outcomes used in measurement of a health promotion program aimed at reducing health inequalities differ extensively from those used in traditional health care evaluation (Themessl-Huber et al, 2008). Further, it is argued that the traditional approach neglects the “slow moving process of institutional evolution and resultant incremental changes in population health” (Siddiqi and Hertzman, 2007) provided by health promotion programs. Such “slow moving processes” are necessary to change the societal structures that allow inequalities to exist.

In order to be able to properly use evidence in relation to health promotion activities, a shift in thinking about how we measure and evaluate effects of health promotion campaigns is necessary, particularly when we attempt to evaluate health promotion through an equity lens. If we are not able to measure inequalities and the effect of health promotion in distinguishing inequalities, then the evidence will not be available to ascertain the value of such activities. But, because of the continued reliance on traditional health care

research data in health promotion programs, we are presented with a Catch-22 situation. We need evidence to be allowed to carry out equity-based health promotion programs, but if programs are not designed and evaluated with an equity lens, then we can't reach definitive conclusions on the effect of such programs on equity, and therefore, it is difficult to convince people of the necessity of such health promotion programs to reduce inequalities (Taylor and Marandi, 2008).

IDEOLOGY AND HEALTH PROMOTION

Countries like the USA place high value on individual liberty, and are hesitant to enact policies or programs that might be seen to impinge on individual freedom. However, this line of thinking can conflict with the aim of reducing inequalities, particularly if we take into consideration the view that in order to eradicate disparities, we need to target their root social and structural causes (Mechanic, 2002). In a comparative study between the US and Canada, Siddiqi and Hertzman (2007) found that public provision and income redistribution are more important than national economic success where population health is concerned, and that the development of public provision has long-term effects on health status (see also Wilkinson and Pickett, 2009). Mechanic (2005) says that the desire to reduce inequalities is often at odds with political will and priorities that may have other goals, economic interests or ideology in mind.

Structural changes to reduce the impact of smoking on a society, for instance, might be seen as a worthwhile cause for losing some individual liberties, but this may be because the evidence-base exists to demonstrate the detrimental effects of smoking on all parties. However, even here, the long struggle by the tobacco industry and its corporate allies against the evidence and policy changes is important to remember. Structural changes to reduce the impact of other behaviours and risk factors, such as diet, might not be able to win general support, and therefore there might be more political reluctance to implement such changes. Qualitative research from the UK showed that individuals of higher socio-economic status placed blame for health inequalities on lifestyle choices and behaviours, rather than acknowledging that there are actual societal differences between the groups (Davidson et al, 2006). A prominent ethos of individualism — rather than collectivism — can lead to what Baum (2007) describes as “victim blaming.” While it should be acknowledged that individual choice does have a strong effect on health

outcomes, particularly in relation to non-infectious diseases, there is growing evidence that people need supportive environments in order to make healthy choices (Baum, 2007).

Another key political issue in relation to equity and health promotion programs is that effective programs would require action from a variety of political sectors — not just the health sector (Low and Theriault, 2008). For those who ideologically believe in limited government and personal liberty, this is a difficult sell, which is why the issue of ideology is a real barrier towards reducing the inequality gap.

Conclusion

If we want to reduce the gap that exists in health between the wealthy and the poor, then we need to look at health promotion activities and programs through an equity lens. In the literature on reducing health disparities through health promotion, there is a consensus that such programs need to target the fundamental causes of disadvantage and be participatory in nature (see Frohlich et al, 2008; Phelan and Link, 2005; Themessl-Huber et al, 2008; Capewell et al, 2010). Equity focused programs would not just seek to address individual disease or behaviour, but would look for solutions outside of a traditional health model (Williams et al, 2008). The actual determinants of health inequalities cannot just be found in the health sector, but rather are grounded within wider social problems (Themessl-Huber et al, 2008). A key challenge for future research, policy and program development is identifying and evaluating the best balance between individual focused and structural universal health promotion programs.

There also appears to be room to develop understanding as to why the uptake of health promotion programs in disadvantaged groups is traditionally low. It would be useful to look at this with a specific behaviour in mind — diet and physical activity at school, for instance. Future research could also focus on programs unique to individual nations. As discussed, national ideology and the prevalent attitude towards health and health promotion differs by country, and has a great effect on the ability of interested parties to have an impact on equity in health. A comparative analysis of attitudes, ideology and politics could enable us to find evidence of the effectiveness of health promotion.

A key issue to keep in mind, however, is that in order to view health promotion programs through an equity lens, we must ensure that the issue of health equity is at the forefront during all stages — from design, through

data collection and dissemination. A review of the effect of mass media campaigns to promote smoking cessation found that such campaigns tended to lack effectiveness in disadvantaged communities, because they didn't take into consideration the different needs of those socio-economic groups (Niederdeppe et al, 2008).

Research that is just concerned with measuring overall health outcomes does not necessarily provide information on the effect of the intervention or program on disadvantaged groups, and this is problematic when we are trying to establish the potential benefit to such groups. This is particularly important when we are trying to persuade policy makers of the benefits of a program to reduce social inequities — it is difficult to implement structural changes at the national or local level if there is no evidence of disproportionate effects on different social groups.

Structural changes are key to dealing with issues that affect disadvantaged groups. An evaluation of a 2005 British Columbia Smoking Cessation Campaign found that the campaign performed poorly in disadvantaged communities because of their general higher exposure to cigarette smoking (Gagne, 2007). Rose (1985) argued that it is important to change the norms associated with behaviours in order to benefit population health. For health promotion and equity, this norm-changing behaviour would have its roots at the structural level.

This paper highlighted that health promotion programs need to be targeted to disadvantaged populations most at risk and adapted to take account of the specific needs and social circumstances of particular populations. When programs rely solely on individual initiative, there is a danger that they are disproportionately taken up by the more affluent or connected in society.

While evaluation is necessary for establishing evidence for best practice, we need to rethink the model of evaluation to make it more appropriate for health promotion generally and inequity specifically. Existing theoretical frameworks established by traditional medical research can serve as a barrier to equity in health. Further, political ideology plays a role in whether or not structural changes that target the root problems of inequality are feasible. Finally, in order to reduce inequalities, it is important that we not only target behaviour, but target the root causes of inequality and disadvantage.

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