Poor suburbs and poor health: exploring the potential of a locational approach to reducing health disadvantage in Australian cities.

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Dedication

This thesis is dedicated to my children: Zac, Ben and Karl – who give purpose to everything.
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This thesis was completed with much help, advice and friendly support. My thanks goes to my principal supervisor, Professor John Macdonald, and to my co-supervisors Dr Don Dingsdag and Dr Betty Gill. Thank you also to the people who were kind enough to answer my questions and emails: Dr Boyd Hunter, Professor Gavin Mooney and Dr Gavin Turrell. For ongoing encouragement I thank my dear friends, Beth Macgregor and Dr Jane Elix, and my parents, Patrick Gethin and Pamela Gethin. Finally, to my ex-husband Alex Damon, my extensive gratitude for his endless patience and for proofing the thesis.
Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

(Anni Gethin, 2007)
Table of contents

1 Introduction..........................................................................................................................9
  1.1 Introduction and research aim..........................................................................................9
1.2 Concepts and terminology ..............................................................................................14
  1.2.1 Health inequalities or health inequities? .......................................................................14
  1.2.2 Health disadvantage and socio-economic disadvantage ..............................................14
  1.2.3 Stratification: class, income or education? ...................................................................15
  1.2.4 Location ......................................................................................................................16
  1.2.5 Approach, policy and intervention ..............................................................................16
1.3 Theoretical framework ...................................................................................................17
  1.3.1 The need for a theoretical framework ..........................................................................19
  1.3.2 Critical social science ................................................................................................23
1.4 Research design: rationale, methods, literature selection and research questions.............27
  1.4.1 Theoretical perspectives ...............................................................................................27
  1.4.2 Research aim ...............................................................................................................28
  1.4.3 Available evidence ......................................................................................................30
  1.4.4 The selection of literature ...........................................................................................31
  1.4.5 The research questions ...............................................................................................32
1.5 Limitations, delimitations and other issues .......................................................................45
  1.5.1 Limitations ..................................................................................................................45
  1.5.2 Delimitations ...............................................................................................................46
1.6 The contribution of this thesis ...........................................................................................48
1.7 Conclusion ...........................................................................................................................49

2 The pathways between socio-economic inequality and health disadvantage..........................52
  2.1 Introduction ....................................................................................................................52
  2.1.1 The approach taken to the health inequalities literature ..............................................52
  2.2 The damaging effects of inequalities on health ................................................................54
  2.2.1 Explanatory theories: psychosocial and neo-material positions ....................................57
  2.3 Exploring causal pathways: reverse causality, health services and health behaviours ........59
  2.3.1 Poor health causes low income .................................................................................60
  2.3.2 Impact of health services ............................................................................................61
  2.3.3 Lifestyle and health behaviours ....................................................................................63
  2.4 The psychosocial position ...............................................................................................66
  2.4.1 Relative deprivation and income inequality .................................................................67
### 2.4.2 Plausibility of psychosocial pathways ............................................................... 71
### 2.4.3 Social capital/social support and individual health ............................................. 76
### 2.4.4 Psychosocial vs neo-material analysis: the income inequality debate ............. 78

### 2.5 The neo-materialist position: an argument about fundamentals ............ 82

### 2.6 Pathways to health through the life course .................................................. 85
#### 2.6.1 Early life ......................................................................................................... 86
#### 2.6.2 Unemployment and sole parenthood ............................................................. 89
#### 2.6.3 Lifecourse approach ..................................................................................... 91

### 2.7 Social and economic context ....................................................................... 92

### 2.8 Conclusions ................................................................................................... 94

### 3 Can the problem of health disadvantage be solved or reduced? .................. 99
#### 3.1 Introduction ................................................................................................... 99

#### 3.2 Framing the problem .................................................................................... 101
##### 3.2.1 The psychosocial understanding ............................................................... 102
##### 3.2.2 The neo-materialist understanding ........................................................... 102
##### 3.2.3 Proposed approaches ................................................................................ 103

#### 3.3 What approach to use? ................................................................................ 103
##### 3.3.1 Narrowing the income and wealth gap ....................................................... 103
##### 3.3.2 Policies to alleviate socio-economic and health disadvantage .................... 106
##### 3.3.3 Addressing cause or effect? ........................................................................ 109

#### 3.4 How could the proposed approaches be achieved? .................................. 110

#### 3.5 The need to identify the deeper causes of health inequalities/health disadvantage ........................................................................................................... 113

#### 3.6 Conclusions .................................................................................................... 115

### 4 Social exclusion: a framework for understanding health disadvantage .......... 118
#### 4.1 Introduction .................................................................................................... 118

#### 4.2 What is social exclusion? ............................................................................. 119
##### 4.2.1 Definition used in this research ............................................................... 121

#### 4.3 The dimensions of social exclusion ............................................................... 123
##### 4.3.1 Poverty ........................................................................................................ 123
##### 4.3.2 Does unemployment equate with social exclusion? ................................. 126
##### 4.3.3 Do other social circumstances of social exclusion need to be considered? ................................................................. 128
##### 4.3.4 The deeper causes of social exclusion ....................................................... 129
##### 4.3.5 How does social exclusion happen? ........................................................... 131
##### 4.3.6 Social exclusion and stratification ............................................................. 134
4.4 Excluded spaces: the relationship between location and exclusion .... 140
4.5 Conclusions................................................................................................. 143

5 Does location matter? The relationship between location and health........................................................................................................... 147
5.1 Introduction ................................................................................................. 147
5.2 Composition................................................................................................ 149
5.2.1 The usefulness of compositional effects ................................................ 152
5.3 Context......................................................................................................... 153
5.3.1 Critique of contextual studies................................................................. 155
5.4 Conclusions................................................................................................. 165

6 Location, socio-economic disadvantage and health disadvantage in Australia......................................................... 168
6.1 Introduction ................................................................................................. 168
6.2 A causal model................................................................................................ 172
6.3 The distribution of low income households in Australian cities ......... 174
6.3.1 The reasons for disadvantaged locations .............................................. 175
6.3.2 The dimensions of locational disadvantage .......................................... 188
6.4 The locational divide: Sydney case study ............................................. 190
6.4.1 Measuring poverty: what is poor, what is a disadvantaged location? ........ 191
6.4.2 Method ..................................................................................................... 192
6.4.3 Data analysis ............................................................................................ 193
6.4.4 Results ...................................................................................................... 196
6.4.5 Discussion of the study results............................................................... 201
6.5 Conclusions................................................................................................. 204

7 Locational approaches to addressing socio-economic disadvantage and health disadvantage. ....................... 209
7.1 Introduction ................................................................................................. 209
7.2 A locational approach to disadvantage: brief overview....................... 211
7.3 Rationale for locational approach............................................................... 213
7.4 Critique of a locational approach............................................................... 216
7.5 Specific locational policies........................................................................ 220
7.5.1 Health equity spending........................................................................ 220
7.5.2 Early intervention.................................................................................. 223
7.5.3 Social mix................................................................. 230
7.5.4 Social capital............................................................. 233

7.6 Conclusions........................................................................ 239

8 The Mt Druitt case study...................................................... 242
8.1 Introduction ...................................................................... 242
8.2 Mt Druitt – location profile.............................................. 244
  8.2.1 Compositional issues.................................................. 246
  8.2.2 Contextual effects...................................................... 247
  8.2.3 Locational advantages and disadvantages.................... 249
8.3 Study method..................................................................... 250
8.4 Categories of interventions............................................... 255
8.5 Effective interventions: examples and analysis.................. 262
  8.5.1 Examples of effective interventions (by category).......... 263
  8.5.2 Analysis: what constitutes an 'effective intervention'? .... 269
8.6 Challenges to interventions............................................... 282
  8.6.1 Intervention/organisation related............................... 283
  8.6.2 Systemic problems.................................................... 285
  8.6.3 Can the problems in Mt Druitt be addressed by locational interventions? 289
8.7 Conclusions..................................................................... 291

9 Discussion and conclusions.................................................. 297
9.1 Introduction ...................................................................... 297
9.2 Health disadvantage: causes and solutions....................... 298
  9.2.1 The primary role of socio-economic factors.................. 298
  9.2.2 Possible solutions..................................................... 302
  9.2.3 The deeper causes.................................................... 304
  9.2.4 Barriers to overcoming social exclusion...................... 306
9.3 What can a locational approach achieve?......................... 307
  9.3.1 The relationship between disadvantaged location and health 308
  9.3.2 The locational patterning of the socio-economic determinants of health 309
  9.3.3 The role of public housing......................................... 311
  9.3.4 Potential population reach of a locational approach........ 312
  9.3.5 What can locational policies and interventions achieve? 314
  9.3.6 Challenges at the grassroots...................................... 319
9.4 Contribution of this thesis................................................ 321
9.5 Limitations of this thesis.................................................. 323
9.6 Conclusion: where to now for a locational approach to reducing health disadvantage?................................. 326
List of tables

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table 1</td>
<td>Sydney suburbs: concentration of very low income households (&lt;$400)</td>
</tr>
<tr>
<td>Table 2</td>
<td>Sydney suburbs: concentration of low income households (&lt;$500)</td>
</tr>
<tr>
<td>Table 3</td>
<td>Sydney suburbs: concentration of vulnerable households (&lt;$600)</td>
</tr>
<tr>
<td>Table 4</td>
<td>Sydney’s poorest suburbs (ranked by concentration of low incomes &lt;$400 [%]).</td>
</tr>
<tr>
<td>Table 5</td>
<td>Mt Druitt: indicators of disadvantage (%)</td>
</tr>
<tr>
<td>Table 6</td>
<td>Organisation abbreviations</td>
</tr>
<tr>
<td>Table 7</td>
<td>Targeted services interventions.</td>
</tr>
<tr>
<td>Table 8</td>
<td>Individual and family interventions</td>
</tr>
<tr>
<td>Table 9</td>
<td>Community interventions</td>
</tr>
<tr>
<td>Table 10</td>
<td>Physical environment and infrastructure improvement</td>
</tr>
<tr>
<td>Table 11</td>
<td>State Government funded intervention packages</td>
</tr>
</tbody>
</table>

List of figures

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Figure 1</td>
<td>Relation of life expectancy and gross national product per capita in OECD countries 1993</td>
</tr>
<tr>
<td>Figure 2</td>
<td>Per capita GDP in US dollars (parity adjusted) and life expectancy in 155 countries , 1993</td>
</tr>
<tr>
<td>Figure 3</td>
<td>Causal pathways to health disadvantage</td>
</tr>
<tr>
<td>Figure 4</td>
<td>Cardiovascular deaths by SLA, Sydney, NSW</td>
</tr>
<tr>
<td>Figure 5</td>
<td>Social exclusion, socio-economic disadvantage, location and health disadvantage</td>
</tr>
<tr>
<td>Figure 6</td>
<td>Relationship between low income households and unemployment rate (by Sydney suburb)</td>
</tr>
<tr>
<td>Figure 7</td>
<td>Relationship between low income households and percentage of sole parent families (by Sydney suburb)</td>
</tr>
<tr>
<td>Figure 8</td>
<td>Relationship between unemployment rate and percentage of sole parent families (by Sydney suburb)</td>
</tr>
<tr>
<td>Figure 9</td>
<td>Mt Druitt suburb map</td>
</tr>
</tbody>
</table>

List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>DOH</td>
<td>Department of Housing (NSW)</td>
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<tr>
<td>LGA</td>
<td>Local Government Area</td>
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<td>SLA</td>
<td>Statistical Local Area</td>
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</tbody>
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Abstract

Poor urban Australians face a substantial health disadvantage: on average, they can expect to die earlier and suffer more physical disease, mental illness and injuries than wealthier Australians. This thesis examines the potential of one approach to reducing the problem of health disadvantage, namely, systematically intervening in disadvantaged locations. Such an approach is gaining support, especially in the United Kingdom and Australia; there is therefore a need to determine its possibilities and limitations.

The thesis is written from the theoretical perspectives of critical social science and political economy of health. The research synthesises empirical data and critical analysis, combining findings from the health inequalities literature and analyses of contemporary political and economic contexts. It also includes two original studies:

- a quantitative analysis of the patterning of socio-economic disadvantage in Sydney suburbs, and

- a qualitative case study of a disadvantaged location: Mt Druitt, NSW.

The health inequalities research shows that reducing health disadvantage is largely a question of reducing socio-economic disadvantage. A model of social exclusion is used to show how socio-economic disadvantage develops in capitalist societies. Following from this analysis, it is argued that a locational approach can have little impact on the macro political and economic antecedents of socio-economic and health disadvantage.

Given these macro constraints, the thesis examines the possible ameliorative impact of a locational approach to health disadvantage – here too, there are many limitations. A locational approach would have a limited population reach as most health disadvantaged people do not live in identifiably disadvantaged locations. Location itself creates only a modest independent burden on health, thus improving the amenity of disadvantaged locations will contribute little to reducing health disadvantage.
In Australia, the creation of the most visibly disadvantaged urban locations is almost entirely a consequence of policies to concentrate public housing. Although it can be expected that locational interventions will be focused in these locations, there are substantial policy barriers to addressing the major socio-economic determinants of health – low income, unemployment and sole parent poverty – in public housing estates.

Location based policies to alleviate aspects of health and socio-economic disadvantage are assessed. In general locational policies and interventions have had a disappointing track record in buffering populations against issues such as poverty, unemployment and childhood disadvantage. Four specific policies are examined. There is a case to provide improved health services in disadvantaged locations. Measures to improve social capital or change the social mix of locations will have a very small, if any, impact on health. Early intervention in disadvantaged locations is rational in that the precursors of health and socio-economic disadvantage occur in early life; however, population reach is limited and only the most expensive and intensive of these programs have produced good results.

The case study of Mt Druitt shows that agencies are willing to implement a wide range of interventions to alleviate location based socio-economic and health disadvantage. Some of these interventions can be expected to have good results for some individuals. However, there is a lack of a systematic approach to problems in this location, and substantial barriers exist to creating widespread positive change.

Overall, despite growing interest in a locational approach to addressing health disadvantage, and evidence of considerable energy at grass root level, a locational approach can be expected to contribute little to improving the health of socio-economically disadvantaged urban Australians.
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1 Introduction

"It is one of the greatest contemporary social injustices that people who live in the most disadvantaged circumstances have more illnesses, more disability and shorter lives than those who are more affluent."[1]p.xxi.

1.1 Introduction and research aim

There is an extensively documented health disadvantage facing Australia’s poorer residents, who can expect, on average, to die earlier and suffer more disease, mental illness and physical injury than wealthier Australians.[2-4] This phenomenon is common to all wealthy nations,[5-8] where, despite great relative affluence, each has a hierarchy of population health mirroring the socio-economic strata. Socio-economic factors are now viewed as the main cause of potentially reducible health differences in affluent populations; in essence, the poorer a person and the longer they are poor, the worse their health is likely to be.

These 'health inequalities' have become the focus of intense research activity and of growing interest amongst health policy makers. Although all except the wealthiest groups in society suffer some comparative health adversity, those on the lowest incomes suffer the largest disadvantage – it is these 'health disadvantaged' people who are the focus of this thesis. There is also cause for alarm in many nations, including Australia, that, despite general improvements in population health the health gap between rich and poor is beginning to widen further.[6, 9-11] A major challenge facing the public health sector is that of reducing such inequitable health outcomes, the fundamental origins of which appear to lie in the way societies are organised and wealth is distributed.
1. Introduction

The aim of this research is to explore the potential of one possible means of reducing the problem of health disadvantage in Australia, namely the approach of targeting interventions in socio-economically disadvantaged urban locations (hereafter termed 'disadvantaged locations'). Written from the theoretical perspectives of 'critical social science' and 'political economy of health' the research synthesises empirical knowledge and critical theoretical analysis, drawing from the health inequalities literature and analyses of contemporary political and economic contexts.

There are a number of reasons for investigating whether targeting interventions in disadvantaged locations can reduce health disadvantage. A vast body of research has emerged documenting and explaining the complex links between socio-economic disadvantage and health disadvantage; however, solutions to the problem are only beginning to be explored.[12-14] Some of the numerous factors found to link health and socio-economic disadvantage include differences in: maternal nutrition, early childhood experiences, access to health services, unemployment, stress levels, health behaviours and degree of control at work.[15-23] Collective variables have also been shown to influence the health of socio-economic disadvantage groups; for example, neighbourhood quality[24] and a nation's social and health infrastructure.[25]

However, there is little point, some argue, in responding to these factors by themselves; rather, what is really necessary is to address the root causes of socio-economic disadvantage and health disadvantage.[26-28] It has been asserted that this would (and indeed should) be achieved primarily through income redistribution;[26, 29, 30] narrowing the wealth gap would reduce many of the material and psychological impacts associated with being comparatively poor that have a negative impact on health. Whilst this proposal has theoretical
merit, (discussed in detail in Chapter 3) it faces significant political obstacles, as indicated, for instance, by the recent widening of income inequality in the United Kingdom, Australia, Canada and the United States.[31-34]

In the absence of measures to address fundamental causes, it has also been argued that health disadvantage could be alleviated through social, economic and health interventions.[28, 35] These could be aimed at addressing the causes of socio-economic disadvantage directly (e.g. by reducing unemployment), alleviating the material and/or psychological disadvantages of being poor (e.g. by providing subsidised in kind services such as public transport), or by intervening to lessen the impact of lower income on health (e.g. by increasing health services and social services provided to low income earners). There is reason to believe that policies of this nature may be more politically acceptable to many governments than direct income redistribution. In Australia, the United Kingdom and the United States, for example, whilst there have been few efforts to ensure a more equitable distribution of income, there have been a host of other social and economic interventions aimed at disadvantaged groups (these are discussed in Chapter 7).

It is, however, important to note that health disadvantage is seldom the driving force which compels governments to intervene to address socio-economic disadvantage. Rather this latter issue concerns governments in the main because of related problems such as spiraling welfare costs, unemployment, crime and urban decay (this issue is discussed in Chapters 4 and 7). Even so, the effectiveness of policies in reducing these problems is still of great interest, even when not enacted in the 'name of health'; that is, it can reasonably be expected that successfully reducing socio-economic disadvantage will also reduce health disadvantage.
1. Introduction

One of the distinguishing characteristics of United States and European policy initiatives to alleviate socio-economic disadvantage has been a strong emphasis on locational targeting.\[13, 36-39\] This approach involves focusing interventions in specific locations identified as suffering socio-economic disadvantages, ranging in size from large regions to small neighbourhoods. In Europe in particular, the approach has been used in conjunction with generalist policies (e.g. with a national employment program or across the board increases in welfare spending) and also as a principal means of addressing specific issues (e.g. urban decay, localised unemployment and transport problems).\[40, 41\] Locational policies have also been used specifically to reduce health disadvantage; for example, in England and Scotland there have been efforts focused in the most severely disadvantaged locations.\[36, 42\]

There have also been moves in Australia to address socio-economic disadvantage at a locational level, albeit almost entirely at a state rather than federal government level.\[43\] This is illustrated by the fact that, although the federal Coalition government (from 1996- time of writing), has not developed locational policies aimed at reducing socio-economic or health disadvantage, current state governments have, to varying degrees, intervened at a locational level to alleviate the impact of socio-economic disadvantage on people, including on their health; for example, there are policies in disadvantaged locations in all Australian states, particularly in areas of concentrated public housing.\[44-49\]

There is a clear need to find ways of reducing health disadvantage that are both effective and likely to find political and financial support. The approach of intervening in disadvantaged locations has the advantage of a track record in the current political climate in Europe, Australia, the UK and the US. However,
1. Introduction

It is still to be established how effective a locational approach is in reducing health disadvantage, both for the targeted population (resident in those locations) and across the whole population of health disadvantaged people. Although these questions are important they cannot actually be answered at this point of time, both because locational policies have only been partially implemented and also because health disadvantage is caused by multiple factors interacting across the life course. Thus, it is not possible in the short-term to evaluate the full effects of policies aimed at the reduction of the problem.[42]

In addition, there has been very little evaluation of any policies to alleviate health disadvantage, locational or otherwise.[13]

What is possible, and the aim of this research, is to determine the potential effectiveness of a locational approach to reducing health disadvantage. That is, to assess whether intervening in this manner is capable of reducing health disadvantage, given what is known about the causes and locational distribution of the problem and its underlying social and economic determinants. Exploring these issues, it is argued in this thesis, is fundamental in determining whether or not this approach should be advocated as a way of reducing health disadvantage in Australia.

The following sections of this chapter:

- define some of the concepts and terminology used in the research
- discuss the theoretical framework underlying the research, and
- explain the research design (including the rationale, selected research methods, selection of literature and the questions around which the research is structured).
1. Introduction

This outline is followed by a discussion of the delimitations, limitations and other pertinent issues relating to the research, and a summary of the contribution this research makes to knowledge about health disadvantage.

1.2 Concepts and terminology

Although, in general, the concepts and terminology are explained as they arise, this section explains some of the fundamental concepts that are used throughout the research.

1.2.1 Health inequalities or health inequities?

Socio-economically patterned health differences between people are usually termed 'health inequalities' and less commonly 'health inequities'.[50] Harris and colleagues argue for the use of the latter term to encapsulate the view that the poorer health and shorter life spans of poorer people are fundamentally inequitable and unjust, rather than simply differential.[50] Whilst this is a position shared by the author, the term 'health inequalities' is used in this research because it is the most commonly used term when referring both to the phenomenon and to the associated body of research.

1.2.2 Health disadvantage and socio-economic disadvantage

The term 'health disadvantage' is used to describe the excess burden of death and disease faced by socio-economically disadvantaged people in affluent nations. It is a term applied collectively rather than to individuals, reflecting the fact that although the poorest sector of the population has the worst health, within this sub-population there are individual variances. Socio-economically disadvantaged people are defined, in this thesis, as being those who are in the bottom 25% to 30% of household income earners in a nation and who are subject
to the processes of 'social exclusion' (these processes are defined and discussed in Chapter 4). There is no precise income cut-off for those suffering health disadvantage, as many people move in and out of being socio-economically disadvantaged. In general, the longer a person is socio-economically disadvantaged the worse their health; thus the term 'health disadvantage' is also understood as being cumulative.

'Health disadvantage' is sometimes described simply as 'health inequalities', but, more correctly, the latter term describes the existence of unequal health outcomes across the socio-economic gradient, including more advantaged groups. Accordingly it was considered necessary to clearly distinguish between the two terms.

1.2.3 Stratification: class, income or education?

When discussing health disadvantage and health inequalities it is necessary to refer to social stratification in some manner, given that this discourse is essentially concerned with how and why people's health varies in relation to their position in society. In general, regardless of how stratification is measured, be it by income, education, socio-economic status, occupational, economic or social class, health will vary according to the hierarchical arrangement of these categories (this is explained in Chapter 2). It could therefore be argued that, for descriptive purposes, which measure is used is not of great importance, and researchers do use a wide range of categories. In this research, except when referring to specific studies, the term 'socio-economic status' and 'socio-economic status groups' are used to describe general stratification. The terms 'socio-economically disadvantaged' and 'socio-economic disadvantage' are used
to describe those in the lowest socio-economic status group (who also suffer health disadvantage – see above).

1.2.4 Location

Location is used to describe distinct geographical areas, which for the purposes of this thesis, and in the Australian context, mainly range in size from small neighbourhoods, through to local government areas, and include suburbs, postcode areas and groups of suburbs (such as the 11 suburbs of Mt Druitt). In this thesis the term location is mostly used in conjunction with the concept of 'disadvantage'. That is, the issue being considered is whether the approach of intervening in identifiably disadvantaged locations is likely to be effective in reducing health disadvantage. Of course the possibility exists that the actual size of a locations selected area may influence the effectiveness of such an approach, and this issue is discussed in Chapters 5 and 6.

1.2.5 Approach, policy and intervention

The terms 'locational approach', 'locational policy' and 'locational intervention' are used throughout the research. These terms are used in order to distinguish clearly between the different interventional levels being discussed. 'Locational approach' refers to the general notion that social or health problems can be addressed through activity at a locational level – a locational approach is distinguishable from a generalist approach, in which no particular location is favoured. 'Locational policy' refers to instances were more specific issues are focused on at a locational level, by a government or other agency; for example, a government could have an early intervention policy or a health equity spending policy that it targets locationally. 'Locational intervention' refers to what is actually done to implement a particular policy; examples of interventions would
be supported play groups or increasing funding to community health centres in disadvantaged locations. A number of interventions could be included within a specific policy.

1.3 Theoretical framework

…the way health and illness are defined as well as the material reality of disease and death, will vary according to the social and economic environment in which they occur. This is not to suggest that the physical and chemical laws governing disease mechanisms can be abandoned, but rather they must be seen to operate in a social and economic context that is constantly changing.[51]p.47.

The research methodology employed in this thesis draws on the theoretical perspectives of critical social science and political economy of health. The implications of these theoretical influences for this research are discussed in the following sections. Additionally, the rationale for taking a theoretical perspective at all is given, as health inequalities research is frequently undertaken without any theoretical positioning.

Critical social science researchers typically take the view that critique is intrinsic to understanding society and social practices, and that researchers using such a perspective are committed to progressive social change.[52, 53] Whilst most forms of critical social science share these characteristics, the term 'critical social science' has been used to refer to the critical theory of the Frankfurt School theorists,[52] as an umbrella term for a range of critical sociological perspectives including Marxism, neo-Marxism and feminism[54], and also to identify a general critical tendency in social science.[52, 53] The characteristic that these sometimes disparate approaches share is emphasis on critique of the status quo and promoting the interests of the disadvantaged and oppressed.
Political economy of health, in its broadest sense, is the position which holds that the causes of health and illness and the provision of health services are strongly influenced by political, social and economic systems.[51] It also contains the value position that health equity is desirable and is furthered by a critical analysis of the underlying causes of health and health care disparities. In this sense, political economy of health is seen to be theoretically consistent with critical social science or is even a form of critical social science (for instance, a critical social science approach to health). Within the health inequalities literature a political economy perspective is most usually synonymous with a Marxist analysis (e.g. see [51, 55-57]), although clearly, as within political economy itself, a wide range of theoretical positions could share the descriptive term. Political economy of health is specifically identified in this research because of the dominant place given to political and socio-economic considerations.

It would have been conceivable to identify this research as being simply political economy of health, as it lies distinctly within this discourse (that is, it critically considers a health issue within its political and socio-economic context). A problem for the author arose when it was considered that there needed to be a clearly articulated epistemology to justify the approach and methods used in this research – however epistemology is not generally a concern of political economy of health researchers. Critical social science is both theoretically consistent with political economy of health and specifically addresses epistemological issues, thus it has been used to provide the necessary theoretical foundations. These are discussed in more detail in the next section.
1. Introduction

1.3.1 The need for a theoretical framework

Political economy of health aside, it is actually unusual for health inequalities researchers to state or reveal (for instance through terminology) a theoretical perspective.[58-60] This has meant that researchers’ theoretical understandings of the creation of health inequalities are, in general, either absent or merely implied,[59] even though social and economic inequalities are widely understood as the root cause of the problem. For Marxist scholar Navarro this atheoreticism, certainly in the US, is to be explained by the dominance of corporations in research funding. He argues that the critical impetus within health inequalities research during the 1960s and 1970s has been abandoned in favour of bland acceptance of the political and social status quo.[60] Without questioning the validity of Navarro’s arguments (directed predominantly at the American context), atheoreticism seems to be endemic in the field; a similar lack of theory is also apparent in the work of many British, Australian and Canadian researchers who are, conversely, mostly state funded university academics.

In many instances the absence of explanations for socio-economic inequality appear to be a consequence of the central role of epidemiology[61] and its associated methodologies[58] in health inequalities research. Epidemiology is a science well suited to demonstrating the links between socio-economic inequality and health outcomes, for example to show that heart disease is higher amongst low income groups or that experience of low income across a lifetime increases the risk of early death. It is not, however, a social science with a body of social analysis and theory upon which its practitioners might draw. Thus, in itself (and as would be expected), epidemiology is not equipped to explain the causes of socio-economic inequalities nor their enduring nature. Of course, there is nothing to prevent epidemiologists from working in an interdisciplinary way,
nor alternatively to stop social scientists incorporating epidemiological work in their analyses.

One group of researchers who certainly appear to straddle both social science and epidemiology are those who identify their field as the sub-discipline of 'social epidemiology'.[62] Research from this sub-discipline, which largely focuses on documenting and explaining health inequalities, has increased exponentially since the 1980s.[63] However, there are fundamental differences between the approach taken of most social epidemiologists and that being undertaken in this research.

In general, it could be said that the question that drives social epidemiology is 'how do social and economic factors affect health?' This can be extrapolated from the focus of the sub-discipline on measuring the impact on health of factors such as income inequality, social support, social networks, work pressures and human emotions (see for instance [62]). It has also involved the development of increasingly sophisticated empirical measures of these types of complex social and economic factors. Despite the intricacies of this research, it has been argued by Kaplan, a champion and constructive critic of the sub-discipline, that the question of 'why?' needs to be addressed more fully.[63] By 'why' Kaplan means: 'why are the causes of different health outcomes distributed differently by socio-economic position?'[63] An illustration of the approach Kaplan describes would be explaining why socio-economically disadvantaged people smoke more, and not just that they do smoke more. Questions of this nature are clearly important when trying to understand and address health inequalities, and one returned to by the author through this thesis. The position taken here (in this thesis) is that it is also of fundamental importance to understand what drives socio-economic inequality in the first instance – for example, to
understand why people become poor or unemployed and how these problems are perpetuated.

It could be argued that across the field of health inequalities the integration of social science (including social factors, social analysis and social theory) and epidemiology is still a work in progress. Whilst the overwhelming importance of social and economic factors in determining health inequalities has been the focus of many researchers, these are often added to explanatory models in a static way,[61] for instance in diagramatic form by a series of boxes or in very general terms such as ‘the social system’ (e.g. [64]). However, simply including social and economic variables does not operationalise them and is hence of limited usefulness.[61] There has also been criticism of the use of ‘implicit social theory’ in which a model of society and social processes is assumed rather than made explicit.[65] This approach, in essence, means that the current society is viewed uncritically without any causal analysis of the creation of income inequalities or the operation of vested interests in their perpetuation.[60]

For the reasons outlined above there have been calls for health inequalities researchers to engage more closely with research into socio-economic inequalities and social policy and with social, economic and political theory.[61, 66-69] This concern in turn raises the question of which research and theories are most appropriate.

Graham argues that an interdisciplinary framework is needed to better understand health inequalities: a framework in which social and policy analysis is added to epidemiology.[61] Her proposal is to include an analysis of the global processes behind 'social exclusion' (i.e. the contemporary divisions in wealth and opportunity in affluent nations) and some of the ways in which
social policy might moderate its effects on populations. This approach provides a clear advance for researchers attempting to understand the current causes of socio-economic inequality underlying health disadvantage, as opposed to viewing them as a 'given'. In addition, it suggests some possible policy initiatives that would improve socio-economic equity and accordingly, could be expected to reduce health disadvantage.

This thesis takes a similar approach to Graham’s, and the processes and consequences of social exclusion are analysed and discussed: the factors that underlie health disadvantage are identified, as are the issues which will need to be addressed in any approach designed to alleviate the problem. There are, however, two important elements missing from Graham’s analysis (and she does identify her analysis only as a starting point). It does not contain an analysis of the vested and ideological interests in creating and perpetuating social exclusion, nor an explanation of why governments in different nations have developed quite different policy responses to the problem. Whilst this research does not draw heavily from social theory to explain these phenomena, consideration of these questions is included in the analysis.

There is a long history within the discipline of public health of recognising the influence of politics and power on health policy and the social and economic determinants of health.[70, 71] Within the contemporary health inequalities discourse, this type of analysis is mostly in evidence from the Marxist and Marxist influenced theorists (e.g. [28, 67, 72-75]. These theorists are distinguished by the explicit connection of a political analysis to social theory (i.e. Marxism or political economy of health). That is, rather than just explaining the effects of political processes, for example the pursuit of neo-liberal policies, the operation of these processes is explained through their connection to an
underlying class conflict between the corporate (or ruling) class and the working class. The existence of policies that favour one class over another in particular nations is linked to the relative ascendancy of each class and the history of class struggle in that nation.[67]

Whilst the Marxist model has explanatory strengths in relation to health inequalities, the view is taken here that 'critical social science' is a more accurate descriptor of the theoretical perspective taken in this thesis. That is, if the critical impulse of Marxism is retained but many of its elements abandoned (including a commitment to revolutionary change, a determinist model of history, and dualistic class schemata) then the perspective is more properly termed 'critical theory'[76] or 'critical social science'.

1.3.2 Critical social science

This section discusses the theoretical perspective of critical social science and explains how this perspective influences the research design and methods. The discussion also details how the theoretical understandings relate to research into health disadvantage in general and this research in particular. This discussion serves to demonstrate the strengths of critical social science in understanding the problem of health disadvantage and exploring solutions to this problem.

Critical social science does not claim to operate from a 'value neutral' position; rather, at its heart is a normative commitment to reducing human suffering and emancipation from oppression.[77-79] The analysis of social problems and determining the means of their resolution are therefore at the forefront of the research endeavour. From a critical social science perspective the reasons for researching health disadvantage are:
1. Introduction

- it is a social problem which creates human suffering
- the problem unfairly burdens the poor and disadvantaged, and
- there is a commitment to reducing or eliminating the problem.

Social problems are understood as historically specific and as determined by the prevailing economic, political and social contexts.[53, 80, 81] It is not possible to 'remove' problems from the context in which they are created in order to study them, but rather to critically examine the ways in which problems are shaped and influenced by social and economic structures. Furthermore, the existence of hegemonic ideologies that foster the idea that prevailing social systems are rational and natural need to be identified. The epistemological position of critical social science is therefore that knowledge and critique are interdependent;[53] understanding the social world combines these in a dialectical process.[79]

Therefore, when researching health disadvantage using a critical social science approach, there is recognition that both the problem and the 'facts' about the problem are produced in a context. Failing to acknowledge and specify the elements of context can only result in a partial understanding of the problem. Additionally, if health disadvantage is presented in a way which recognises context but without identifying the repressive elements of the context (i.e. uncritically) or the existence of power (vested interests in the status quo), then the researcher is either defending the status quo or presenting it as natural and immutable rather than something constructed by humans which may be changed. This stance implies when researching and addressing contemporary social problems (including health disadvantage), it is necessary to examine the role of market capitalism in creating these problems – including: the ways in
1. Introduction

which this system operates, the power structures it contains and the ideologies that justify its contingent inequalities.

This approach is consistent with the position presented by the Frankfurt School of critical theorists, that a theory of society needed to be grounded in a theory of capitalism because of its constitutive role in social life.[81] Although not all contemporary critical social scientists share this view [52](e.g. some branches of feminism), when researching health disadvantage from a critical social science perspective it appears essential to use a model of how capitalism operates. For instance the close relationship of health disadvantage to the distribution of income indicates the need to explain why income is distributed in this way. Thus, although this thesis is not highly theoretical, (say, in the sense of using theories of the capitalist state, capitalist crisis and uneven urban development) it does build from a model of ‘capitalism of the present age’. The model used draws from Byrne’s neo-Marxist analysis of social exclusion (see Chapter 4).

The centrality of context in the creation of knowledge is also linked to the critique of positivism within critical social science. Positivism is a theoretical position that has been dominant in western science and influential within social science. It is the stance that it is possible to understand the world from a value-free position through empirical methods and that there are objective ‘facts’ to be discovered.[82] Although science has moved from an absolutist position more to one of probabilities, there remains a prevailing attitude both that science can be removed from other interests and that the world can be best understood through empirical means.[83]

In contrast the critical social science position is that science should not be privileged above philosophy and theory:[77, 81] understanding the world is
achieved through a synthesis of empirical scientific research and theorising. This synthesis is dialectical in that each influences the other, concepts are developed in relation to empirical research and those concepts are shaped by what is observed. In other words, the theories we have about how the world is and the concepts we use to understand the world will influence our experience; objective material conditions, in turn, influence forms of thought and knowledge.[79, 81] Concepts are therefore not absolutist but contingent on the material conditions and social system at a given time. The purpose of theory is not to derive ‘truth’ but to achieve particular goals relating to understanding suffering and emancipation. As historical conditions change, so there is a need for concepts and theories to change to those more appropriate for achieving this end.[81]

The shift to a post-positivist social science has important ramifications for the study of health disadvantage, a field of inquiry that has been dominated by scientific approaches. The critical social science critique of positivism is strongly suggests that the answers to the problem cannot be found through scientific means alone by either the refining of methodologies or using increasingly large data sets or increasingly complex methodologies. It suggests the need to be sceptical of explanations which use the association of empirical facts to develop a causal theory of that relationship with no reference to the contexts or interests involved, or without being explicit about which theory of society is implied in such a causal relationship. In addition, the critical social science position on social theory suggests that rather than searching for a fundamental explanation for health disadvantage that is true for all time, researchers need to examine the context specific to their time and how it creates and perpetuates health inequalities.
## 1.4 Research design: rationale, methods, literature selection and research questions

The development of the research design was driven by a number of interrelated factors, including the:

- theoretical perspectives of critical social science/political economy of health
- thesis aim, and
- available evidence for researching this aim.

These sections explain the rationale for research design, the research questions around which the research is structured, and the analysis and methods which are used.

### 1.4.1 Theoretical perspectives

In broad terms taking a critical social science perspective means that the research:

- emphasises the political and socio-economic factors which affect health inequalities,
- is cross disciplinary, and
- uses a combination of theoretical analysis and empirical data to reach the research conclusions.

There are no predefined critical social science research methods: "it is the way that the empirical evidence is approached and interpreted, the methodology not
1. Introduction

the method of data collection *per se*, which characterises critical social research."[53]p.106. That is, in order to be consistent with a critical social science approach, empirical evidence can be obtained through a variety of means, but needs to be contextually contextualised through a critical analysis of the prevailing political and socio-economic order.

The methodology used by political economy of health researchers is consistent with the critical social science approach. In general, the work of political economy of health researchers is characterised by taking epidemiological data and/or health issues and adding a socio-economic/political causal explanation for what has been observed, where the causal explanation is developed through empirically based theories explaining social, economic and political and policy processes (see for example [51, 57]). As with critical social science there are no stipulated methods which a political economy of health researcher must use, for instance with quantitative analysis of large data sets, qualitative case studies, and secondary analysis all in evidence.[57]

Given these fairly broad methodological parameters the development of the research design was guided by what analysis and methods could most adequately address the research aim.

1.4.2 Research aim

The aim of the research is to explore the potential of a locational approach to reduce health disadvantage in urban Australian populations. In the introduction to this chapter it was explained that this aim was expressed in terms of 'potential' because it is not possible to investigate this question through a purely empirical approach (even were this considered desirable). This is so firstly because locational policies and interventions to address health disadvantage are
insufficiently numerous (particularly in Australia) to provide anywhere near sufficient data to detect an impact at population level. Secondly, health disadvantage is a complex problem, the consequence of an accumulation of myriad assaults to health across the lifecourse (see Chapter 2), so evaluation of interventions for most health outcomes would need to use longitudinal research of at least several years duration.

Preliminary reading identified three broad areas that would need to be researched in order to explore the research aim (these were subsequently refined into a series of research questions [see below]). The identified areas were the:

- causes of health disadvantage
- relationship of location to health disadvantage, and
- track record of locational interventions to address socio-economic disadvantage.

It was apparent that researching these areas would be necessary to show whether:

- the causes of health disadvantage could possibly be ameliorated at a locational level
- health disadvantage was patterned or influenced by locational level factors (which interventions could target), and
- past locational policies and interventions designed to address socio-economic disadvantage had been successful (and therefore potentially capable of addressing health disadvantage).
1. Introduction

Exploring this aim was also constrained by the state of existing knowledge (e.g. what is known to cause health disadvantage) and what data could practicably be collected by the author.

1.4.3 Available evidence

Whilst developing these questions it became apparent that there were a number of relevant sources of theory and secondary data which could be used. These included:

- the health inequalities literature (a large body of literature concerning the patterning and causes of health disadvantage/inequalities)
- the health and place literature (a sub-set of the health inequalities literature explaining the relationship between location and health)
- theories explaining socio-economic inequality
- data and analysis concerning socio-economic inequality in Australia (at a general and locational level), and
- evaluations and analysis of the actual and potential impact of locational interventions on the socio-economic determinants of health disadvantage (e.g. anti poverty programs, early intervention, provision of extra health services and social capital interventions).

It also became apparent that certain data would be useful to explore the research aim but, to the best knowledge of the author, it was not available (that is, the data did not exist in published or unpublished format).

This data related to:
1. Introduction

- the concentration of low income households in Australia, and
- how health and other workers implement interventions in disadvantaged locations.

Accordingly, two small studies were conducted by the author to collect this data:

- a secondary analysis of Australia census data to indicate the concentration of low income households in Sydney, and the correlations between unemployment, sole parenthood and public housing by location, in Sydney NSW, and
- a qualitative study of locational interventions in a socio-economically disadvantaged location.

The reasoning behind undertaking these particular studies is explained in the discussion of the research questions, which follows.

1.4.4 The selection of literature

The thesis utilises a wide range of theoretical and empirical cross disciplinary research. The rationales for the literature selected to be used in the thesis are explained in more detail in the relevant chapters. The main issue was that research and theoretical papers needed to be selected from the enormous volume of potentially relevant literature – given it was not practical to include thousands of research papers. At an overall level the literature was selected in order to provide a rigorous and fair exploration of the arguments considered in the thesis. Included were:
1. Introduction

- All the main expositions and critiques which formed the central debate within the health inequalities literature (see chapters 2 and 3)

- Statistical data on demographics, distribution and incidence of death and disease and socio-economic (for example, as produced by the Australian Bureau of Statistics)

- A range of peer reviewed representative studies across all topics covered in the thesis (to illustrate and provide evidence for examples, and to show evidence of a range of impacts or views)

- Meta-analyses and reviews (where available – to provide a summary of impacts of particular socio-economic conditions or interventions)

- Applicable studies on Australian urban socio-economic disadvantage (examining the depth, causes and characteristics of socio-economic disadvantage in Australian cities), and

- Theoretical papers arguing either for or against the concept of intervening locationally to alleviate health or socio-economic disadvantage

1.4.5 The research questions

This thesis is structured around a series of linked research questions, with each chapter focused on one question or a number of related questions. These questions were, as explained above, developed from the initial broad areas of inquiry – the discussion here explains the purpose of asking each question and the analysis and methods involved in exploring the questions.
1. Introduction

1.4.5.1 What causes health disadvantage? (Chapter 2)

There is a formidable literature documenting and seeking to explain the creation of health inequalities/health disadvantage in affluent nations. The critical review and synthesis of this literature enables the establishment of an evidence base on which to build the research. That is, it identifies the factors which would, on the available evidence, need to be addressed when attempting to reduce health disadvantage. Thus, various approaches to ameliorate health disadvantage examined through the thesis can be gauged against this evidence.

There are, however, a number of challenges presented by the health inequalities literature. These include its volume (it grows constantly), its scope, (more and more causal factors being identified) and the existence of a central dispute around causal primacy (determining what type of factors are most important in determining health inequalities). A number of strategies were used to overcome these issues. There was no attempt to cover all the health inequalities literature, because this is unfeasible, but also because many studies are simply further illustrating the primary link between socio-economic status and poorer health outcomes for different diseases and subpopulations without addressing the issue of what causes these difference at a more fundamental level. The view is taken that since the existence of health inequalities is very well established, this issue need not be explored at length. Rather, what is of primary interest is why these inequalities exist, and particularly why socio-economically disadvantaged people experience a health disadvantage.

The review is largely structured around the central and fundamental debate within the literature: whether a lack of material resources (neo-materialist position) or social and psychological factors (psychosocial position) is of
1. Introduction

primary importance in explaining health inequalities. This strategy has a number of useful outcomes. It enables key areas of consensus to be identified (factors which both groups of researchers understand to adversely impact on health) and also allows critical evaluation of the debate and of the evidence on which there is disagreement. Overall, the discussion of the debate indicates which directions could be most useful for reducing health disadvantage.

It does need to be acknowledged that the evaluation of this debate is from a particular perspective. That is, the critical social science/political economy of health stance that social and economic context are of primary importance in understanding issues, correlates closely with the position taken by neo-materialist health inequalities researchers (and indeed some of these researchers could be located within the discourse of political economy of health). However, this does not mean ipso facto that the arguments of these researchers are viewed as being correct, rather the arguments of each side are evaluated on the basis of their logic and the supporting evidence.

The evidence base produced by exploring this research question has three main features, it:

- identifies the areas of core agreement in the literature
- identifies factors which have been asserted to cause health disadvantage but for which the evidence is uncertain or implausible, and
- synthesises the two competing theoretical positions to account for the impact of both material and psychosocial factors on health disadvantage.
1. Introduction

This chapter develops a causal model of health disadvantage, firmly grounded in a critical analysis of the health inequalities literature.

1.4.5.2 *Can the problem of health disadvantage be resolved or reduced? (Chapter 3)*

This question focuses the thesis on the issue of whether and how health inequalities and health disadvantage might *theoretically* be eliminated or ameliorated. The purpose of this discussion is to:

- theoretically delimit the problem: given the best possible circumstances is health inequalities/disadvantage actually a resolvable/ameliorable problem?, and
- map out the various theoretical solutions to health disadvantage proposed by neo-materialist and psychosocial theorists.

These issues are important to consider even though they are not directly connected to the core issue of locational interventions – where Chapter 2 demonstrates which issues would need to be addressed to ameliorate health disadvantage, Chapter 3 considers if and how these issues could be addressed. Exploring these issues involves:

- assessing proposed approaches to reduce health disadvantage against the evidence base of what causes the problem (Chapter 2), and
- considering whether the approaches and associated policies and interventions are/have been enacted by governments.

In this latter issue this chapter is also important because it is here that the case is made for the consideration of political and socio-economic context. Contextualising research is integral to the critical social science/political
1. Introduction

economy of health perspective, but this chapter shows specifically why it is important in exploring the research aim of this thesis. Critically examining the view that health disadvantage needs to be resolved by governments taking particular actions, leads to the discussion of why governments have not taken the actions that researchers have proposed (e.g. redistributing income). This examination leads to the research questions explored in the subsequent chapter.

1.4.5.3 What is the political and socio-economic context for health disadvantage? (Chapter 4)

These questions build from the previous theoretical discussion and bring the political and socio-economic context into direct consideration. That is, if, as researchers argue, addressing health disadvantage is largely a question of addressing socio-economic disadvantage, then the nature and causes of socio-economic disadvantage need to be understood.

Understanding socio-economic disadvantage has been an ongoing and dominant concern within social science and political economy, hence there are vast tracts of social and economic theory which could be drawn upon for a thesis of this nature. For pragmatic reasons it was not possible to delve at length into those bodies of theory, so it was decided to select a theoretical model using the criteria that it did the following:

- explained contemporary socio-economic and political forms
- explained why a sector of affluent populations was socio-economically disadvantaged and marginalised
- was useful for understanding the creation of health disadvantage and conceptually compatible with theories explaining health inequalities
1. Introduction

- was consistent with empirical evidence for the patterning of socio-economic disadvantage, and

- explained the locational dimension of socio-economic disadvantage.

These criteria are consistent with the critical social science position that theory be both empirically grounded and oriented toward problem solving rather than abstract 'truth'(see above).

On the basis of these criteria, a dynamic model of social exclusion was selected to be used in the thesis; this model is dynamic in the sense that it is both descriptive (it identifies which people are socio-economically disadvantaged in society) and causal (it explains what processes had caused these people to be socio-economically disadvantaged).

Using this model of social exclusion the chapter discusses how a sector of the population in affluent nations has come to be excluded from full economic and social participation, experiencing relative poverty and insecure employment. It is argued that the creation of social exclusion is not a matter of chance but the result of deliberate policies with clear benefits for employers. Discussing these issues clearly identifies the deeper causes of political and socio-economic inequality and the processes which perpetuate inequality. This provides a framework to assess a locational approach to address health disadvantage; asking to what extent the approach can overcome the forces creating and maintaining the 'causes of the causes' of health disadvantage?
1. Introduction

1.4.5.4 What is the relationship between socio-economically disadvantaged locations and health disadvantage? (Chapter 5)

Having established the context in which the problem of health disadvantage occurs, the research changes focus in Chapter 5 to consider the issue of location and health directly.

The position is taken that if a locational approach to reducing the problem of health disadvantage is to be justified there must be some sort of relationship between location and health disadvantage. That is, if there were not such a relationship, interventions to reduce health disadvantage would only be delivered at a locational level for reasons of administrative convenience, with no one location necessarily favoured above another.

Within the health inequalities literature there is also a sub-literature focusing on 'health and place' or, more specifically, the role location has in patterning and creating health disadvantage. Some of the research it contains is suggestive of a possible role for locational interventions in reducing the problem of health disadvantage: namely, that health disadvantage is both concentrated by location, and influenced by aspects specific to location. These two issues are in fact the central foci of the 'health and place' literature, in which they are most often referred to using the terms 'composition' and 'context'. However, it is important to note that the implications these issues have for locational interventions is seldom directly considered in this literature.

This chapter does not contain a full review of the 'health and place' literature, as this was considered neither necessary nor useful; rather, the research is selectively analysed to determine if there is evidence for the questions (above) and how this evidence relates to reasoning for location specific interventions.
1. Introduction

'Selective analysis' means the following: in relation to the issue of composition, several major studies are referred to which show a clear patterning of health disadvantage by location in Australia and other affluent nations. The implications of this patterning are then considered. In relation to context (the independent effect location has on health) various studies and meta-analyses of studies are referred, of sufficient number to show the range of sizes of contextual effects of location, and to highlight the various explanatory frameworks that have been developed to explain these effects. The issues of 'effect size' and the utility of explanatory frameworks in relation to locational interventions are then considered. The purpose of this discussion is to:

- determine if the effect of location is sufficiently large to justify locational interventions, and
- assess whether the causes of locational effects can actually be determined with accuracy (this would need to be the case if this information were to be used to guide interventions).

1.4.5.5 How are the socio-economic determinants of health disadvantage locationally patterned in Australia? (Chapter 6).

This question focuses the research on the relationship between location and the socio-economic determinants of health in Australia. The research and discussion build on the conclusions of Chapters 2, 4 and 5, bringing together in the Australian context consideration of the following factors: the socio-economic determinants of health disadvantage, the causes of social exclusion and the patterning of health disadvantage by location. This is an important step in the research because it shows:
1. Introduction

- what issues will need to be addressed by locational interventions to reduce health disadvantage in Australia, and

- the likely population reach of a locational approach to health disadvantage in Australia.

The research undertaken in this chapter has two methodological components: discussion and analysis of existing research, and a quantitative study. In the earlier chapters the key issues in relation to location and health disadvantage are identified as: low income, sole parenthood, unemployment and locational disadvantage. Existing research is analysed to determine how and why these factors are locationally distributed in Australia to show, for instance where low income households tend to be located and why unemployment and sole parent families are concentrated in particular locations. It does need to be acknowledged that these issues are still being explored by economic and social researchers – even so, there is sufficient research to begin identifying the possibilities and barriers to a locational approach to health disadvantage in Australia.

The issue of the concentration of socio-economic disadvantage has not been specifically investigated in existing research (as noted above). That is, it has not been determined in Australia how many socio-economically disadvantaged people live in locations where a sizable proportion of other people are also socio-economically disadvantaged (although assessment of this measure, known as poverty concentration, is common in the United States (e.g.[84]). In addition the relationship between concentration of disadvantage and sole parenthood, unemployment and public housing (all strongly associated with health disadvantage) has not been examined at a city level in the Australian literature.
1. Introduction

It was considered that determining the concentration of socio-economic disadvantage was necessary because it would give an indicator of the population reach of a locational approach to address health disadvantage. In other words, it would show how many of the target population would be reached in an approach focusing on disadvantaged locations. It would also indicate if the criticism made of locational approaches to addressing disadvantage that 'they miss more people than they include'[27] – was valid for Australia.

The additional correlations between disadvantaged locations and the factors of sole parenthood, unemployment and public housing were also examined to determine if there was a relationship between these variables and location. The reason this determination was to assess if there was statistical support for the assertions that the:

- states of unemployment and sole parenthood are possibly causally related, and

- extent to which public housing has a concentrating effect on socio-economic disadvantage.

Both these issues have implications for a locational approach to address health disadvantage.

Although it was not feasible to conduct an analysis of the location of socio-economically disadvantaged people in terms of their household expenditure, determining concentration by household income was relatively straightforward. This approach clearly has some limitations, in that low income does not always
mean socio-economic disadvantage, however low income levels do provide a reasonable indicator of the likelihood of socio-economic disadvantage.

Secondary data analysis of Australian Bureau of Statistics (ABS) statistics was used to determine concentration of low income households by suburb for Sydney. In addition, the correlations between low income, sole parent, unemployed and public housing households in Sydney, NSW were determined from ABS data. The method used in this study and the implications and limitations of the findings are explained in detail in Chapter 6.

1.4.5.6 How effective are locational policies in addressing the determinants of health disadvantage? (Chapter 7)

In the chapters preceding Chapter 7 the scope of a locational approach to health disadvantage is mapped out, clarifying what populations and problems the approach can potentially be directed towards. The question here, given this theoretical scope, is what a locational approach can be expected to achieve. This question is explored in two parts. The first part of the chapter considers the potential of a locational approach to address the wider socio-economic inequalities which underlie health disadvantage. The second part of the chapter analyses the potential of four specific locational policies. The question was researched in this way because it is not yet possible to determine the success or otherwise of locational policies specifically designed to improve health (see above); however, locational policies aimed at reducing poverty and its effects (that is, the socio-economic determinants of health) have a far longer history and, in some instances, quite extensively documented results.

The approach taken in the first part of the chapter is to:
1. Introduction

- discuss the track record of locational approaches to alleviating poverty and uneven locational economic development, and
- analyse the arguments supporting and critiquing a locational approach to socio-economic inequality.

This method provides an overview of the outcomes of locationally targeted policies and interventions in promoting socio-economic equity in recent decades, and indeed whether they can ever effectively reduce the gap between rich and poor. As these issues are entire research fields in themselves, they are dealt with relatively briefly within the confines of the chapter.

In the second part of the chapter locational policies (and the associated interventions) are discussed in more detail. The four polices discussed are:

- health equity spending (allocating more health resources to disadvantaged locations)
- early intervention (support for young children and families)
- social mix (changing the ‘income mix’ of households in a location), and
- social capital creation (building community links and cohesion).

These policies were selected on the basis that they are directed at the socio-economic determinants of health disadvantage and either have been implemented in practice or could readily be implemented. Although, having said so, with the exception of ‘early intervention’, these policies have not been formally evaluated to any great, or long term, extent. The discussion of these policies therefore focuses on their rationale and the outcomes they have
1. Introduction

achieved or could achieve, as well as the implications of applying these policies locationally.

This range of policies is discussed because it provides an illustration of whether in practice a locational approach can, or is likely to, have a positive impact on the socio-economic determinants of health disadvantage.

1.4.5.7 What possibilities and barriers exist when intervening to address the causes of health disadvantage at a locational level? (Chapter 8)

The focus of Chapter 8 is also on interventions in practice, and here research centers on a specific location: Mt Druitt (Sydney), NSW. A qualitative case study is used to examine the experiences of workers implementing interventions in a disadvantaged location. The reason for conducting this study was to further examine the potential of a locational approach to health disadvantage – what appears possible in theory must at some stage be implemented by workers, who themselves face particular opportunities and challenges. A selection of workers involved in locational intervention were interviewed and asked what they considered influenced the likelihood of success or failure of locational interventions. They were also asked to reflect on the influence of socio-economic context on the problems with which they dealt. The method used in this study is described in detail in Chapter 8.

Although it is not possible to generalise from a qualitative case study, the purpose of including this study was to provide further insight into the potential of a locational approach to address health disadvantage by discussing what actually happens within a disadvantaged location.
1. Introduction

1.4.5.8 Conclusions (Chapter 9)

The thesis is concluded in Chapter 9. Here the main findings of the research are summarised, the contribution of this research detailed and some directions for further research suggested.

1.5 Limitations, delimitations and other issues

1.5.1 Limitations

This research explores an issue influenced by an enormous array of variables. It is also an issue for which relevant research is massive and continually expanding. As such, it was simply not possible to survey all the relevant literature, given its vast nature, and the cross disciplinary span. Accordingly the literature was surveyed selectively; the rationale for the selection of literature to be included in the thesis is outlined in the research questions sections (above) and the chapters themselves. For pragmatic reasons (i.e. writing up and constructing the research), a publication cut-off date for inclusion was set at mid 2004.

Much of the research drawn upon for this thesis is incomplete; incomplete in the sense that it concerns preliminary investigations, is based on limited cases or sub-populations, or is part of a developing field in which knowledge and methods are still being refined. Of course, it is only possible to use the best and most relevant research available, but this is done on the understanding that new insights and knowledge will develop in the future which could be of relevance to the research area of this thesis.
1.5.2 Delimitations

1.5.2.1 Indigenous health

A discussion of Australian health disadvantage should not fail to mention the health of indigenous Australians, with the often cited 20 year deficit in life expectancy and far higher rates of all diseases of affluence and poverty than other Australians. However, indigenous health and disadvantage are not discussed to any great extent in this research (although Chapter 8 does consider some of the issues for people designing interventions aimed at indigenous residents in a community). This is because the tragic state of indigenous health derives from a complex set of reasons requiring a specific focused investigation – one which is beyond the scope of this thesis.

1.5.2.2 Non-urban populations

This research relates mostly to disadvantaged urban populations. Australians living in rural and remote areas, indigenous people in particular, do face distinct health disadvantages and exclusionary processes; however, as these processes differ from those affecting urban populations it is beyond the scope of this research to consider them.

1.5.2.3 Gender, ethnicity and culture

Issues of gender, ethnicity and culture are also minimally represented in this thesis, not because they are unimportant mediators of health disadvantage, but because the focus is on socio-economic and political processes. Including these additional factors would enormously increase the complexity of what is already a complex piece of research. Furthermore, although gender, ethnicity and culture potentially affect both health and the determinants of health, they do not reverse the general socio-economic patterning of health disadvantage. Having
1. Introduction

said this, actual interventions implemented by people working in the field will
be confronted with these issues; for instance, ethnicity and culture emerge in the
qualitative study in Chapter 8, so this is an area in which there are clearly
grounds for further detailed research.

1.5.2.4 Other issues

If all but the wealthiest in society suffer a health disadvantage, the question
arises at why there should be a focus only on the most disadvantaged, when
there are health improvements to be made across the population. Despite this
concern, there are a number of practical and moral reasons for focusing at the
level of greatest disadvantage.

In a project as vast as the amelioration of health disadvantage it is necessary to
begin somewhere. From a critical social science/political economy of health
perspective, those with the greatest disadvantage are the logical starting point.
Of course, it must be recognised that even the poorest Australians have better
health and longer life expectancy than most of the world’s population. Ideally,
efforts would be directed at resolving this issue and the underlying gross global
inequity. However, given that vast sums of money are being spent on health in
most industrialised nations, it is still possible to argue that this money needs to
be spent in just ways. That is, if the moral equation is (albeit questionably) one
limited to each affluent nation state, then it is this author’s belief that the group
suffering the greatest socio-economic disadvantage (and hence health
disadvantage) must always take precedence. In addition, there is also an
obligation to allocate resources in ways most likely to be effective; socio-
economic inequality, as the biggest cause of amenable health differences in the
affluent world, calls for research and practical attention.
1. Introduction

1.6 The contribution of this thesis

This research makes a number of contributions to knowledge, furthering both the understanding of the problem of health disadvantage and critically examining a possible means of reducing health disadvantage. These are briefly summarised here (and discussed in more length in the concluding chapter).

Overall, the thesis develops an original synthesis of cross disciplinary research and critical analysis and applies it to understanding a research problem. This synthesis draws from:

- the health inequalities and health and place literatures,
- research and theories on the creation and spatial distribution of socio-economic disadvantage in general and in Australian cities, and
- the historic impact and challenges of intervening locationally to alleviate the socio-economic determinants of health disadvantage.

The potential of a locational approach to addressing health disadvantage is assessed using this synthesis. Although there are a growing number of programs in disadvantaged locations designed to promote the health of poor people, an in-depth theoretical exploration of the question has not previously been undertaken.

The research also makes a number of more specific contributions to knowledge. These include the two original studies (discussed above) where new data is presented concerning the:

- challenges of working in a disadvantaged area, and
- spatial concentration of low incomes in Sydney.
1. Introduction

In addition an original position is developed concerning the importance of understanding the role of public housing in creating and perpetuating health disadvantage.

Finally, the thesis also further develops a number of positions (or arguments) concerning health disadvantage and/or socio-economic disadvantage. That is, these positions have already been stated by other researchers (in some instance very briefly), and this thesis develops them in greater detail by drawing on a wider body of research and developing a more in depth analysis. These positions are that:

- it is necessary to incorporate political and socio-economic context into research on health disadvantage
- it is important to recognise the population coverage of a locational approach to health disadvantage (i.e. to determine how many health disadvantaged people it will reach)
- the limited achievements of locational interventions to date in promoting social equity need to be recognised, and
- further explorations into the independent effect of location on health may not be of any great practical value.

1.7 Conclusion

This thesis explores the potential of intervening in socio-economically disadvantaged locations to reduce the health disadvantage faced by socio-economically disadvantaged people living in urban Australia. Researching this issue is a response to the growing recognition of the need to find practical
1. Introduction

solutions to the problem of health inequalities, particularly for those suffering the greatest burden of poor health.

It was argued in this chapter that it is necessary to apply a theoretical model of social and economic inequality to understanding the problem of health disadvantage, despite a general atheoreticism within the health inequalities discourse. In essence this means that not only is it necessary to understand the influence of socio-economic factors on health but also, to engage critically, to understand how these factors are created and perpetuated. This view is consistent with the perspectives from which the research is written, namely critical social science and political economy of health, where placing problems within their wider context guides the development of research design and methods.

The research is designed in order to best explore the aim of the thesis, given the theoretical perspectives involved, the available evidence and evidence which could be feasibly obtained by the researcher. Methodologically, this mode involved a combination of theoretical and empirical approaches, mostly the former. Analysis of contemporary socio-economic inequality is combined with review and analysis of the health inequalities literature and social and economic policy analysis and interpretation. Also, the research includes two empirical studies: a secondary analysis of Australian census data and a qualitative case study.

The thesis is structured around a series of linked research questions, the purpose of which are to determine:

- what causes health disadvantage
1. Introduction

- the relationship of location to health disadvantage, and
- what, if anything, might effectively ameliorate the problem of health disadvantage.

Overall, the thesis covers a broad terrain:

- the complexities of the health inequalities literature
- theoretical analysis as to whether health disadvantage is in fact a soluble problem
- social exclusion and its causes
- the independent effects on health of location; the locational patterning of socio-economic disadvantage in Australia
- the track record of locational interventions to alleviate poverty and address the socio-economic determinates of health, and
- the experiences of workers in disadvantaged locations.

It is intended that taking this broad approach will enable a rigorous and pragmatic exploration of the potential of a locational approach to reduce health disadvantage in contemporary urban Australia.
2 The pathways between socio-economic inequality and health disadvantage

2.1 Introduction

This chapter critically analyses the health inequalities literature, examining its main debates and the evidence concerning how economic and social factors affect human health. The end product of this analysis is a synthesis of knowledge which includes consensual evidence (factors on which most researchers agree) and an amalgamation of aspects of the two major competing explanations for health inequalities (where those explanations are presented as complementary rather than antagonistic).

The analysis and synthesis undertaken in this chapter forms the basis for the chapters which follow, enabling exploration of the following issues:

- whether health disadvantage is a reducible problem, and what approaches could be effective for that end
- the relationship between social exclusion and the determinants of health
- how the social and economic determinants of health operate at a locational level, and
- the likely impact on health disadvantage of locational interventions.

2.1.1 The approach taken to the health inequalities literature

Before discussing the literature it is necessary to make some general comments about health inequalities research and the approach taken to its analysis in this chapter. As mentioned in the introductory chapter, health inequalities research
is dominated by an epidemiological perspective, a field that has not traditionally considered social and economic factors other than as demographic variables. There has also been a tendency to focus on singular causes of disease (specific aetiology) and individual level risk factors.[61, 85] Although this epistemological legacy is still evident there is growing recognition that the messy realities of social and political systems and neighbourhood and individual variations cannot be squeezed into neat models of causality.[61] Increasingly the socio-economic determinants of health are being understood as operating in ways which are temporal, multi-factorial and multi-directional. As a reflection of this multi-causality, explanatory models are becoming more complex. However, if reductionism is a potential problem, then so too is an overly complex analysis in which everything is deemed capable of damaging health.

To avoid these problems the following approach is taken to the literature. The voluminous evidence demonstrating the links between inequality and health (i.e. showing health declining with lower class/income/education) is discussed only briefly, as the evidence for a health gradient is compelling and generally undisputed. The summary of this evidence is followed by a fuller discussion of the possible causes of the health gradient (including the health disadvantage faced by the poorest members of society), organised around the theme of the two competing explanatory frameworks for health inequalities: the 'psychosocial' and 'neo-materialist' positions.

Within this discussion a number of issues are considered. To begin with, some of the common understandings of what underlies health inequalities are critically reviewed: for example, access to health services. This review is followed by a discussion of the evidence supporting the psychosocial and neo-
2. The pathways between socio-economic inequality and health disadvantage

material positions. Included in this discussion is an analysis of what has perhaps been the most contested question in the health inequalities literature: the role of income inequality (or the 'wealth gap') in determining health inequalities. This issue highlights clear differences between the competing positions and provides an opportunity to evaluate the relevance of the concepts of 'relative deprivation' and 'collective social capital' to the issue of health inequalities and health disadvantage. Three factors which have been shown by the research literature to have a major impact on health inequalities and health disadvantage are then discussed: disadvantage in early life, unemployment and sole parenthood. The discussion of these factors demonstrates that both material and psychosocial exposures across the lifecourse are important contributors to health inequalities. The chapter concludes by drawing together the main areas of agreement between the two positions to enable the development of a clearer understanding of how the problem of health inequalities and health disadvantage could be addressed.

2.2 The damaging effects of inequalities on health

Over the last two decades a multitude of studies in the affluent world have shown a strong inverse relationship between the measures of socio-economic inequality (income, education levels or social class) and mortality and morbidity; as the former decrease, so rates of death and disease increase.[5-8] In Australia, a review of 202 articles found overwhelming evidence for this relationship,[3] a finding consistent with the Australian National Health Surveys [86, 87] and the Social Health Atlas of Australia.[4]

The actual health gap between rich and poor is often substantial; for example, in the United Kingdom life expectancy for men in professional occupations
2. The pathways between socio-economic inequality and health disadvantage

exceeds that of the unskilled men by 7.4 years.[88] In Australia, even though figures are usually collected on a locational basis (and hence diluted as the locations are neither uniformly rich nor poor), the poorest quintile of locations\(^1\) experience 1.63 times higher death rates compared to the wealthiest quintile of locations, 1.92 times higher rates of cancer deaths and 2.38 times higher rates of respiratory system diseases.[4] If it was possible to reduce total disease and injury incidence and mortality in all locations to a level equivalent to that of the least disadvantaged quintile, the potential savings in lost years of healthy life could be 17% of the total disease burden.[89]

Although the phenomenon of a socio-economic gradient of health is common to most (if not all) affluent countries, cross country comparisons have found variations in the magnitude of health and mortality gaps between social groups at the top and bottom.[90-92] For example, larger life expectancy and morbidity gaps have been observed in the US than in the UK and Europe.[91, 93] Despite being fraught with methodological difficulties, the existence of national differences in health inequalities has generated great research interest. These differences, it is argued, can potentially reveal some of the underlying pathways between socio-economic factors and health. This issue is returned to below.

Although this thesis focuses on the health of the most socio-economically disadvantaged, it is important to note that the 'health gradient' affects all socio-economic groups, so that in general (as noted in chapter 1), the health of each socio-economic group is worse than the group above. What this indicates is that there are exposures associated with relative lower income and education levels

\(^1\) On the basis of Statistical Local Areas (SLAs) – which are broadly equivalent to Local Government Areas (LGAs).
2. The pathways between socio-economic inequality and health disadvantage

which have an apparent 'dose-response' relationship to poorer health – so that the lower the income and education, the worse it is for health.

Despite the fact that overall morbidity and mortality show a clear socio-economic gradient in all affluent societies, the impact of lower income on health is not uniform for all conditions, or across all sub-populations. There are variations in the health gradient for different diseases and health problems. Thus, for example, there are a few diseases which have higher rates in more affluent groups (reverse gradient), such as breast cancer and malignant melanomas[Adler, 1994 #710]. Also, the gradient can be steeper for some problems than others; with, for example, cardiovascular disease having a far steeper gradient than most cancers.[Deaton, 2002 #7] Understanding exactly why such differences occur is an issue currently being investigated; it certainly does suggest that factors associated with socio-economic disadvantage have a greater impact on the aetiology of some diseases than others.

There are also differences in health inequalities between genders, racial and ethnic groups within countries.[94-96] A shallower health gradient has been observed for women as compared to men, with less marked differences between socio-economic status groups for females.[4, 97] Studies of health inequalities by race (predominantly from the US) have found both substantial differences between blacks and whites and a larger gap between upper and lower black social groups.[95] The association between race and poorer health outcomes is largely, but not entirely, explained by the association between race and lower socio-economic status.[95, 98] (Clearly the issues of the independent impacts of gender and race on health are important, but beyond the scope of this thesis).
2. The pathways between socio-economic inequality and health disadvantage

2.2.1 Explanatory theories: psychosocial and neo-material positions

Within the health inequalities literature, two competing explanations have developed to explain the main causal mechanisms through which socio-economic inequality becomes translated into poorer health and earlier death: the psychosocial and the neo-material positions. The debate between these positions has considered whether social and psychological factors or the material deficits associated with socio-economic disadvantage best account for health disadvantage, but there are also fundamental theoretical and philosophical differences between the two.

The terms neo-Durkheimian and neo-Marxist[99] have also been used to describe the positions from their apparent theoretical origins, but the above terms are used in the most part. Even so (and despite the general lack of interest in social theory in the literature discussed in Chapter 1), the positions can broadly be seen as representing consensus and conflict perspectives on society.²

Psychosocial theorists, consistent with a consensus perspective, recognise the legitimacy of divisions within capitalist society but argue that these divisions need to be reduced because they have become damaging to health. By way of contrast, the neo-materialists have been far more explicit about identifying the 'winners' and 'losers' under capitalism and seeing the systemic division of wealth and power as needing to be addressed. The theoretical differences

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² Within sociology, understandings of society have been broadly divided into conflict perspectives (in which groups or classes within society are seen as having inherently conflicting interests) and consensus perspectives (in which agreement is seen as the basis of social organisation). Both perspectives recognise the existence of social inequalities – conflict theorists see it as a consequence of one group having greater power than the other, whilst consensus theorists understand that differences in roles are functional for the social organisation of labour.

2. The pathways between socio-economic inequality and health disadvantage

between the two positions are examined in more detail in the next chapter, the focus in this chapter being on the strength of the respective explanations for health disadvantage.

At one level the two theoretical positions are a difference of views about what causes health inequalities in affluent nations. Given a relatively wealthy population with generally good nutrition, housing and health and other services, why should there be a large gap between health outcomes for rich and poor? Moreover, and even more intriguingly, why should middle class people do less well than the most wealthy? For psychosocial theorists, it was the latter observation that was of critical interest and can be seen as integral to the development of their position.

Drawing from the studies into British civil servants, the psychosocial theorists developed the case that health differences within relatively affluent groups could be explained by variations in the burden of psychological stress – for instance, as resulting from highly demanding work over which a person has little control. Psychosocial theorists argue that the lower a person is in a hierarchy, the greater stress they experience. [97] This understanding of the psychosocial realm as being the most important explanation for health inequalities was then widened to include collective (societal level) psychosocial variables, such as social cohesion and trust between people.

Conversely, neo-materialists argue that health inequalities are accounted for by a lack of resources, damaging physical exposures throughout a lifetime and deficits in state investment in social services and infrastructure.[101-103] Whilst not denying that psychosocial factors can impact on health, they argue that the psychosocial position is in danger of depoliticising the question of health.
inequalities by detracting from real material differences between people and failure to invest in services in disadvantaged locations.[101]

There is substantial evidence that both psychosocial and material factors can affect health, and it has been suggested that the proponents of these opposing positions have created a false dichotomy[104] by claiming theirs as the ‘most important’ explanation. It is also difficult to separate exactly what has caused the current health status of certain groups: for instance, are the health differences between the most affluent and second most affluent group in society due to different levels of control at work, or small variations in material exposures throughout childhood? Furthermore, material and psychosocial factors are often intertwined; for instance, long term unemployment threatens both financial and psychological well being.

Indeed, in more recent years, theorists have declared that the disagreements may not have been particularly fruitful.[105] However, the psychosocial/neo-material debate is important to review because of the evidence generated by researchers within each perspective about the pathways linking inequality and health, and also because of the different understandings as to what interventions are required to reduce health disadvantage.

2.3 Exploring causal pathways: reverse causality, health services and health behaviours

It is not unusual in discussions of health inequalities to mention the three traditional or commonplace explanations for the problem; namely health selection (where poor health leads to low income), differential access to health services and differences in health behaviours (e.g. see [26, 105, 106]), and then to show that these factors make, at most, only modest contributions to health
2. The pathways between socio-economic inequality and health disadvantage

inequalities. This line of analysis is then used to demonstrate the need to seek other explanations; for instance, the contribution of psychosocial factors.(e.g. [26]). Whilst it is accurate to state that these three explanations do not account for anywhere near the full extent of health inequalities or health disadvantage, it is necessary that they be considered, both because no single factor fully explains the problems and also because, particularly in the case of health services, they have perhaps been too easily dismissed.

2.3.1 Poor health causes low income

It has been argued that one of the reasons for health inequalities is that the incomes of unhealthier people tend to go down, whilst those with better health tend to move up the income scale.[107, 108] If this so called reverse causality hypothesis were correct it would mean that low socio-economic status did not cause poor health, rather poor health causes low socio-economic status. Reverse causality is certainly plausible in suggesting that illness or disability can prevent or limit people’s capacity to work, and hence their income (and socio-economic status) is reduced through downward mobility, part-time work, early retirement or welfare dependence.[105] However, there is only evidence for a small effect of this nature; for instance, Manor and colleagues found modest 'health selection' for young adults,[108] and earlier studies also observed that social mobility was affected by health.[107, 109] Other studies found no evidence for this link across a population,[110, 111] and there has also been some suggestion that reverse causality might actually reduce health inequalities, as people with better or worse initial health are shifted up or down to social strata with respectively higher or lower health status.[111]
2. The pathways between socio-economic inequality and health disadvantage

Additionally, if it is accepted that there is a directional relationship, albeit modest, between health status and socio-economic status, it still needs to be understood contextually; for example, men in lower socio-economic status groups are far more likely to become unemployed after a long illness than those in higher socio-economic status groups.[112] Thus the relationship is seemingly complex, with exposure to factors associated with low socio-economic status leading to poorer health and consequently, poorer health potentially reducing income further. To look at mobility alone ignores the initial effect of socio-economic status.[105] For these reasons it is argued that, although poorer health is a factor which can lead to lower income it needs to be understood from a life-course perspective rather than just isolated instances in time.[105, 113]

2.3.2 Impact of health services

There has been a tendency in the literature to discount the impact of access to health services to the health gradient (e.g. [26, 114] and see [115]). This position follows partially from the work of Mckeown, who showed that medical advances have had only a small impact on improving longevity in western populations.[116] Additionally, there are still marked health inequalities in countries with reasonably equitable access to health care through universal health insurance, such as the Scandinavian countries, the UK and Australia (see for instance [117]).

However, it seems that the role of health services in understanding and responding to health inequalities may have been dismissed too readily. Studies that have sought to account for the impact of differential access to health care within countries have estimated that it explains around ten percent of the gradient.[118] This leads to the argument that health service interventions can
2. The pathways between socio-economic inequality and health disadvantage

only be expected to make a minor impact on health inequalities, and that improving social and economic conditions are likely to be far more important in reducing health disadvantage.[119]

There are a number of points to be made about this observation. First, in a multi-causal problem, in which no cause is likely to dominate, a ten percent proportion, is still substantial enough to warrant attention. Second, studies that look at access to health care do not usually consider the issue of quality of health care, assuming a uniformity in the services to which people have access. In 1971, Hart observed that "the availability of good medical care tends to vary inversely with the need for it in the population served."[120] Indeed, there is contemporary evidence that quality of health care does differ quite markedly within countries by socio-economic status. [121-123] This issue is likely to be important, given that access to quality health services has been found to have a moderating effect on the impact of health inequalities on socio-economically disadvantaged people.[20, 124] The third issue in relation to health services is that of vertical equity – the principle of allocating services on the basis of need – which, in this case, refers to the fact that because the socio-economic disadvantage suffer a greater burden of disease and injury than the rest of the population they should be provided with proportionately more health services. In Australia, it has been shown that socio-economically disadvantaged people do make greater use of health care services,[4] but it has not yet been shown that this is in proportion to the degree of need that exists in this population.

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3 A moderating effect is one which can reduce the impact of adversity, for example providing a buffer to individuals who are exposed to health damaging factors.

2. The pathways between socio-economic inequality and health disadvantage

It also remains to be determined whether providing more services and higher quality health care to socio-economically disadvantaged people can reduce population health disadvantage. This issue is likely to be further complicated in many countries because governments are seeking to contain health care costs; additionally, access to quality health care is becoming increasingly income dependent.[123] Overall, and despite these challenges, the possibility that health services might be an important moderator of health inequalities (through increases in access and/or quality) suggests that it is an issue worthy of more research, and it is one returned to in Chapter 7.

2.3.3 Lifestyle and health behaviours

Given the current focus on healthy lifestyles in Western countries, it is perhaps little wonder that an explanation for health inequalities might be sought in 'unhealthy behaviours'. It has been asserted that the poor are sicker and die earlier because they drink and smoke more, have poorer diets, are more sedentary;[126] indeed health behaviours are the centre of attention in some prominent government reports and health promotion strategies concerned with health inequalities (e.g. see [126, 127]). Of course, if health behaviours were the main reason for health inequities the implication for health policy could be to change the health behaviours of disadvantaged groups. However, the evidence that has emerged from the health inequalities literature shows that links between health behaviour and health inequalities may be of a lesser magnitude and more complex than assumed.

Having said this, the concentration of interest on health behaviours is to an extent understandable, given that behaviours do differ by measures of socio-economic status in ways which could be expected to damage health.[22, 128-130]
For example, a longitudinal study by Lantz and colleagues involving 3617 American men and women found that "persons with the least amount of education and with the lowest incomes were significantly more likely to be current smokers, overweight and in the lowest quintile for physical activity."[22] Australian studies have consistently returned similar findings, for example, Turrell and colleagues identified 51 studies in which potentially health damaging behaviours were correlated with lower socio-economic status.[3] Despite such differences in health behaviours, there are conflicting findings in the literature concerning the impact of these differences on health and mortality, with some research finding generally modest effects [22, 128, 130, 131] and others finding that health behaviours, particularly smoking, account for more substantial proportions of health and mortality differences between socio-economic status groups.[132-134] In addition, when particular diseases are considered (e.g. cardiovascular disease or lung cancer), health behaviours have been found to account for up to a third of socio-economic status group differences.[132]

On the modest side, Lantz and colleagues found that only 8 percent of differences in health status between income groups were explained by differences in exercise, diet, smoking and sleep (collectively).[22] The effect of health behaviours on mortality by income was somewhat higher at around 13 percent. A later follow up study similarly found a modest role for health behaviours.[130] Among researchers observing a more substantial effect for health behaviours, Mackenbach and colleagues found that in some European countries smoking accounted for up to around 30% of differences in mortality risk between different educational groups.[132] The impact of smoking on mortality risk was particularly marked in countries where smoking rates had
declined among the more highly educated whilst remaining constant amongst the less well educated.[132] However, the authors concede that these figures are a fairly crude estimate, due to data collection difficulties; they point out that four other studies of Northern European men found smaller effects, accounting for between 10% and 20% of mortality differences between socio-economic status groups.

Thus, even if the effect of health behaviours is not as high as might be expected, it could be argued that differences in health outcomes, ranging up to a third, certainly make it an issue worthy of attention. The difficulty is that health behaviours are not simply a question of poor choices or lack of education, but are formed and maintained within complex social contexts. This complexity is reflected in the fact that health behaviours have proved notoriously difficult to modify through lifestyle re-education efforts;[127, 135] clearly, there are aspects of the association between socio-economic disadvantage and higher levels of risky health behaviours that also need to be understood.

Wilkinson observes that if health behaviours were not partially affected by the social environment, then they would presumably not differ by socio-economic status.[26] Indeed, there is substantial evidence to show that living in a low socio-economic status household, as a child and/or as an adult contributes to the development and continuation of health damaging behaviours.[22, 26, 127, 128, 133, 136] Possible contributory factors include those of adult role models, habit formation, cultural norms and the use of health risk behaviours as a coping mechanism for difficult and stressful lives.[128, 134] This latter phenomenon is powerfully illustrated by Graham’s study of sole mothers and smoking. For these women, high rates of smoking could not be attributed to ignorance of the
2. The pathways between socio-economic inequality and health disadvantage

health risks; rather, it appeared as a rational choice, providing a cheap source of
pleasure and relief from the drudgery of their daily lives.[136]

Overall, health behaviours are an important contributor to health inequalities
but cannot properly be considered in isolation from the environment in which
they develop.

2.4 The psychosocial position

Broadly speaking, the psychosocial position is that, when it comes to health
differences between socio-economic status groups, psychological and social
factors are far more damaging than material hazards and health behaviours (in
isolation). This placing of the 'psychosocial dimension' as the main intermediary
between social context and poorer health outcomes has constituted a new and
highly influential direction in public health thinking. The strength and
credibility of the psychosocial position has been supported through the
development of plausible new theories and the collection of vast amounts of
supporting evidence. A number of interconnected lines of argument can be
discerned within this position.

The legitimacy of psychosocial pathways has been asserted through presenting
evidence of the effects on health of psychosocial factors, to show that factors
such as stress, social isolation and the experience of distrust correlate with
measures of health. The proponents of this position have concurrently
developed meso-analyses to explain how a psychosocial burden on health is
generated by socio-economic inequality. The most important concepts within
this position are 'relative deprivation' and 'income inequality', discussed in the
next section. In general, the case made for the health damaging potential of
2. The pathways between socio-economic inequality and health disadvantage

psychosocial factors is strong but the 'quasi-sociological' linking explanations have been strongly critiqued – as will also be discussed.

2.4.1 Relative deprivation and income inequality

The central concept of the psychosocial position is that of 'relative deprivation': in affluent societies, the relationship between income and health is not explained by a person’s absolute income but by their income in relation to others in their society. In other words, income by itself (beyond a certain level) is not that important for health inequalities: it is the social hierarchy created by income differences which causes health inequalities.[26, 137, 138] As a simple illustration, relative deprivation means that if everyone in society had the same income and everyone’s income increased except for one person, that one person could expect their health to decline, even though their income had not. When it comes to health disadvantage (the extra burden of ill health suffered by the lowest income groups) this can, according to psychosocial theorists, be largely explained by greater relative deprivation.[26] Relative deprivation differs from the concept of absolute deprivation, where people’s health is damaged because they have insufficient resources to meet their needs for food, shelter and services.

Relative deprivation is argued to affect health through creating a 'psychosocial burden' on health[26, 137] which increases as measures of socio-economic status (e.g. income, education) decline. This burden is a result of number of factors including:

- excessive levels of stress (e.g. from work over which a person has little control)
2. The pathways between socio-economic inequality and health disadvantage

- negative emotional states (e.g. from feeling inadequate or envious)
- increased likelihood of health damaging behaviours
- social isolation (e.g. feelings of loneliness), and
- through less availability of health-enhancing 'social capital' at an individual and collective level (e.g. having little social support or living in a community in which people are distrustful of one another).[26]

The concept of relative deprivation is intrinsically connected to that of income inequality, that is the existence of different income levels in society and the magnitude of the gap between the different income groups. The degree of income inequality (or the way income is distributed in society) is viewed as critical for health. More egalitarian societies, that is societies with smaller differences in income between rich and poor, tend to have better health.[30] This is because, according to psychosocial theorists, levels of relative deprivation and the associated psychosocial burden increase with a wider income gap and decline with a smaller gap. Income inequality is also seen as undermining the collective well being of a society, a point that will be returned to later.

One of the key pieces of evidence in support of the relative deprivation thesis is inter country comparisons. Wilkinson observed that once countries have achieved a minimum level of prosperity (US$10,000 per capita) there does not appear to be a clear relationship between the average income and measures of population health;[30] for instance, Greece has about half the per capita income of the US but longer life expectancy.[30] This is taken to indicate that the income distribution within a country is a more important determinant of health than
2. The pathways between socio-economic inequality and health disadvantage

average income; that is, a poorer country with a more equitably distributed income should have higher life expectancy than a rich inequitable country. Wilkinson sought to demonstrate the general applicability of this argument by showing that for 23 OECD countries with income over US $10,000 per capita there was no clear relationship between per capita income and life expectancy[137] (see Figure 1). This suggests that some factor other than per capita income influences life expectancy.

**Figure 1.** Relation of life expectancy and gross national product per capita in OECD countries 1993 [based on date from OECD national accounts 1995 and World Bank's world tables 1996]. (reproduced from Wilkinson [30])

Although the graph (Figure 1) does appear to bear out Wilkinson's argument of there being no relationship between per capita GNP and life expectancy, a number of questions can and have been raised about the extent to which the data does support his case. That is, there may appear to be little relationship between per capita income and life expectancy for a range of reasons not related
2. The pathways between socio-economic inequality and health disadvantage

to a mechanism of income inequality and the associated increased burden on health of more people being 'relatively deprived'. One reason is that per capita income may not reflect the differences in resources available to the people in these 23 OECD countries; for example, there may be national differences of in kind service provision by governments, which can increase or decrease levels of resources available to lower income earners. Another reason why differences in per capita income may not correlate with life expectancy is that earning a minimum survival income may require different levels of work and resources in different countries; Lynch, for example, makes the point that car ownership in the US is often an essential element in obtaining food, whereas a car is not as important (or even necessary) in other countries for this purpose.[101]

Wilkinson's per capita income comparisons also fail to acknowledge the health damaging factors specific to particular nations which are not directly related to income (relative or absolute), such as homicide rates, warfare or trade embargoes; for example, the use of post Gulf War I Iraq as evidence of the effects of relative deprivation[139] is of questionable value, given the effect of trade sanctions on health in that nation.

These issues aside, perhaps the most damaging blow to Wilkinson's case came from Lynch and colleagues as part of a general attack on the psychosocial position.[101] They demonstrated that there was indeed a correlation between per capita income and life expectancy, once all nations over Wilkinson's US $10,000 cut-off mark were included in the analysis (Figure 2) and not just the 23 OECD nations selected by Wilkinson. This graph (Figure 2) shows a trend for life expectancy to increase with per capita income. This could mean that Wilkinson's sample was too small to accurately reflect this trend and/or skewed by various issues (raised above).
2. The pathways between socio-economic inequality and health disadvantage

Figure 2. Per capita GDP in US dollars (parity adjusted) and life expectancy in 155 countries, 1993. (Reproduced from Lynch et al [101]p.1201.)

However, examining the data presented by Lynch and colleagues shows that it does not allow for a complete rejection of Wilkinson's position. Clearly some wealthy countries have worse life expectancy than some poorer ones (Figure 2), suggesting it is possible that income inequality, and the associated relative deprivation, could have some impact on population health in some countries. In order to consider this issue in more detail it is first useful to consider how psychosocial factors are seen to impact on health – it is these explanations which demonstrate the plausibility of the argument that having less income than others in an affluent country is damaging to health.

2.4.2 Plausibility of psychosocial pathways

There is a vast and growing amount of evidence to show that psychosocial factors can affect health. In other words, the spectrum of human emotional,
psychological and physical responses to the social environment can result in physical damage and earlier death. Health inequalities researchers who have centered on the psychosocial aspects of health inequality have primarily focused on the ways in which measures of socio-economic status are linked to differing levels of stress or capacity to cope with stress.

The neuro-endocrinal system is the biological mechanism understood to link stressful human experience with potential health damage. When humans perceive an event as threatening, they experience a range of physiological changes to prepare the body for defence or escape, often referred to as the 'fight or flight response'. Actual bodily changes include the secretion of stress hormones which speed heart rate, raise blood pressure, move blood to the major muscle groups and raise energy. This is a normal and healthy response to stress; once the threat has passed, further hormones are released which return the body to its resting state.

The stress response system, whilst designed to be protective, can become potentially damaging to the body when over-activated by chronic stress, and it can no longer be turned off, leaving the body in a constant state of arousal. Chronically elevated stress hormones have been associated with reduced efficacy of the immune system, elevated blood pressure and reduced glucose tolerance, and are thought to increase the physiological risks of heart disease; for example, through coronary atherosclerosis.

Psychosocial proponents argue that the experience of being of a lower status in a society can create the kind of chronic stress which erodes physical health and increases the risk of dying. Paralleling the development of a psychosocial case in health inequalities has been the growth in research from
The pathways between socio-economic inequality and health disadvantage

other fields showing the physiological effects of psychosocial factors (for instance, relating to the social relationships within groups) on non-human primates.[145-147] The animal research, often cited by psychosocial researchers, [21, 144] demonstrates that subordinate creatures do have chronically elevated stress hormones, and that this is associated with negative physiological changes, risk factors for disease, and earlier death.[146] This work gives a biological plausibility to the observed poorer health outcomes for individuals suffering excess stresses associated with their subordinate position in the human social hierarchy.

2.4.2.1 The pathways from stress to poorer health

For modern humans, fighting for food and mating opportunities is not so much the issue it might be for animals; rather, it is the numerous stressors associated with lower income status that are viewed as contributing to poorer health outcomes. Factors such as work stress, job insecurity, financial strain, domestic pressures and family breakdown have all been shown to explain part of the relationship between lower socio-economic status and poorer health.[148] There have also been studies that show that the likelihood of damaging health behaviours is increased when people experience these kinds of pressures.[136, 149]

The two Whitehall studies of British civil servants have provided important and frequently cited evidence for the effects of psychosocial factors on people’s health.[23, 26, 150, 151] Particularly pertinent for the line of inquiry into non-material factors was the observation that unequal health outcomes existed even between the top and second ranked from the top groups within the civil service, even though both groups were relatively well paid and highly educated. More
detailed investigations into the reasons for the health gradient amongst these workers led the researchers to conclude that

A combination of factors including features of the work environment (low control, low variety and skill use, high pace, low supports, and low satisfaction), social circumstances outside work (negative aspects of social supports and financial difficulties), and health behaviour (alcohol consumption) do account for a good deal of the social gradient in overall health status and all the gradient in depression and psychological well-being.[97]p.907.

The contribution of work stress to health disadvantage has also been the focus of a wide and growing number of other studies (for overview see [152]). This is understandable, given that experience at work is one of the most obvious differences between socio-economic groups. Jobs requiring great personal effort which are boring and poorly paid, requiring little skill development and with few opportunities for decision making are clearly more likely to be held by people in socio-economically disadvantaged groups. It is these kinds of factors which have been shown to be linked with higher stress levels and poorer health outcomes.

Some studies have observed substantial effects for work related psychosocial stressors on health. For example, levels of control over job related tasks (job control) was found to affect health in 17 out of 25 studies; jobs which are high effort but poorly paid have been shown to increase the relative risk of coronary heart disease by two to six times, and increase the risk of psychiatric disorders and a range of other physical health complaints.[152]

There is also some evidence that stresses from the non-paid work aspects of people's lives can affect their health: for example, Whitehead's comparative
2. The pathways between socio-economic inequality and health disadvantage

study of single mothers in Sweden and Britain. Swedish sole mothers, unlike their British counterparts, are not usually poor or unemployed; they also enjoy an extensive system of social support. Even so, their self rated health was significantly poorer than that of married mothers,[153] suggestive of a range of non-income related factors undermining their health.

Damaging health behaviours are also more likely when a person has stressful living circumstances over which they have little control. It has been proposed that the reason why stress is associated with poor health behaviours is that people use smoking, over-eating and drinking alcohol to help them cope with their difficulties.[136, 154] Thus health behaviours should be understood as a consequence of psychosocial processes rather than just being a characteristic of socio-economically disadvantaged people.

Over recent years, the impact of the psychosocial factors on health, in innumerable facets, has been a strong current in the literature. What might be concluded from this research is that whilst psychosocial factors indisputably do affect health, they do not do so in a clearly uniform way; for instance, psychosocial factors seem to have a greater effect on some diseases than others (e.g. cardiovascular disease), and affect men and women differently, and have differing effects across the lifecourse. In addition, the source of psychosocial stress is not always readily identified. This is shown in the example of job insecurity – it appears to have a negative impact on health, but this may be a proxy for financial insecurity, as demonstrated by a study where the two factors were considered separately: only financial insecurity was found to impact negatively on health.[150]
2. The pathways between socio-economic inequality and health disadvantage

2.4.3 Social capital/social support and individual health

The effect of social relationships and social integration on health is a consistent, if at times confusing, element of the psychosocial position. Variously and interchangeably described as social networks, social cohesion, social ties and/or social capital, researchers have examined how the number and quality of connections people have with one another are determinants of health.[155, 156] For reasons of clarity, these terms will be referred to as 'social capital' in this section.

Social capital has been researched at an individual and collective level in relation to health. For individuals, it involves factors such as the number of friends a person has, their marital status, access to social support and organisational membership.[156-159] At a collective or societal level it has included aggregated individual factors (e.g. membership of organisations across a community) and such factors as voting rates and levels of community trust.[160] The concept has also captured the imagination of a core in the Australian public health community who see that the generation of social capital may provide a means to reduce health disadvantage.[157, 158, 161] (The possibilities of social capital based interventions are returned to in Chapter 7.)

Putnam, probably the most well know proponent of social capital, argues that its elements (family ties, friendship networks participation in social events and affiliation with associations) are some of the most powerful determinants of health and well being. "The more integrated we are in our community, the less likely we are to experience heart attacks, strokes, cancer, depression, and premature death of all sorts."[160]p.326. At an individual level there is substantial evidence for Putnam’s claims: the various components of social
2. The pathways between socio-economic inequality and health disadvantage

capital do consistently correlate with mortality risk, morbidity rates and self rated health.[162-167]

The pertinent questions here are whether deficits in social capital are a contributing factor to health inequalities and/or whether its components can moderate the effects of established determinants of health inequalities (for instance, health behaviours or unemployment). For the former to apply, social capital would need to be a consequence of low socio-economic status and demonstrably affect the health of those of lower socio-economic status. In respect of the latter, it would need to be shown that social capital could buffer lower socio-economic status individuals against health damage.

There is evidence that levels of individual social capital do vary with measures of socio-economic status (i.e. income and/or education).[159, 168] However, it is unclear in terms of causality what effect this relationship might have on health.[169] It has been asserted that social capital is not a mediator between low socio-economic status and poor health; that is, social capital does not form part of the causal pathway between low socio-economic status and poorer health. [159, 170] Pevalin and Rose's study, using the British Household Panel Survey, found that structural factors (including socioeconomic variables) maintained a direct effect on health outcomes even in the presence of social capital and social support measures – concluding that these direct effects were not mediated by the social capital or social support measures.

There is some evidence that social capital could provide a modest moderating or buffering effect for people with low socio-economic status, [159, 170] and a number of writers have asserted the plausibility of the buffering hypothesis.[158, 171, 172] A moderating effect is one which can lessen the
2. The pathways between socio-economic inequality and health disadvantage

damage to health that would otherwise be caused by low socio-economic status; this could mean, for instance, that a low income individual with more social connections could have greater access to help when they were ill.

The concept of social capital overall is far from straightforward, and its potential utility as a health promotion tool has both supporters and detractors. The arguments are considered in Chapter 7, where the view that health disadvantage could be ameliorated by building social capital is discussed.

Although it is possible to measure social capital at an individual level, it makes more sense as a collective concept. That is, it is a measure of the strength of relationships between people and so does not really exist within individuals by themselves. However, the concept of collective social capital as a determinant of health has been considered in the literature mainly as a mediator between income inequality and health, so it is best examined within this framework – to which the discussion of this chapter now turns.

2.4.4 Psychosocial vs neo-material analysis: the income inequality debate

One of the most hotly contested debates within the health inequalities literature has concerned the effects and meanings of income inequality at a population level. This debate was introduced in the discussion of relative deprivation (above), but the aspect of income inequality that has created the most interest within the literature has been its possible contextual impact on health. That is, is income inequality a 'social pollutant' so that, given two nations with equal average incomes, the one with a more even distribution of income can be expected to have better health? Psychosocial theorists have argued that a larger gap between rich and poor can create ruptures in the social fabric, undermining collective social capital (e.g. through declining rates of trust and increasing
crime) and having a substantial effect, not merely on the health of the relatively deprived but also on entire populations.[173] Conversely, neo-materialists have continued to argue that a nation’s average income is more important to health and that a wealth gap is mainly significant for health due to its association with deficits in investment in human infrastructure, rather than the undermining of social capital.[102]

The issue is worthy of discussion for a number of reasons. First, on the basis of the psychosocial arguments and research, the idea that collective social capital could be an independent and important determinant of health has captured the imagination of policy makers and researchers as a possible basis for intervening to reduce health inequalities.[156, 157, 174, 175] It also implies, if psychosocial theorists are correct, that simply redistributing income will bring benefits to population health and reduce health inequalities. The debate also, in itself, reveals some of the clear ideological differences between the two theoretical positions.

Some of the early research into the effects of income inequality on health seemed to suggest that the wealth gap was a major 'killer'. For example, Lynch and colleagues concluded that the differences in mortality between high and low inequality areas in the US were 139.8 deaths per 100 000. "To place the magnitude of this difference in some perspective, an appropriate comparison would be that this mortality difference exceeds the combined loss of life from lung cancer, diabetes, motor vehicle crashes, HIV infection, suicide, and homicide in 1995.”[176]p.1079.

A relationship between state level income inequality and health and/or mortality in the USA was also observed,[177-179] and also specifically within
Texas counties.[180] Lochner and colleagues concluded that "state-level income inequality appears to exert a contextual effect on mortality risk, after income is adjusted for, providing further evidence that the distribution of income is important for health."[178]p.385.

A number of explanations have been asserted for what might account for the observed contextual effect on health. One argument is that the observed effect of income inequality was 'spurious or artefactual', reflecting the curvilinear relationship between income and health.[181, 182] That is, as income increases people's health continues to improve but at a decreasing rate, before leveling off.[183] Hence, greater income inequality would be expected to be associated with worse population health, reflecting the underlying health/ income relationship rather than creating its own independent effects.

Wolfson and colleagues attempted to refute the 'artefactual' explanation by arguing that their research showed that there was an "important association between income inequality and mortality at US state level above anything that could be accounted for by any statistical artifact."[184]p.22. Although Gravelle then defended his initial position,[185] the explanation of statistical artifact clearly failed to impress the psychosocial theorists, for whom the impact of income inequality on health appeared both compelling and clear evidence of the importance of psychosocial factors for health.

According to Wilkinson, a wealth gap creates a 'culture of inequality', a state characterised by a more hostile and less hospitable social environment,[186] and it is this erosion of social capital which damages health. These ideas were expansively developed by Kawachi and colleagues in a series of articles written in the late 1990s.[173, 187-189] They argued that an 'us and them' divide in
2. The pathways between socio-economic inequality and health disadvantage

society has a plethora of health damaging effects: undermining trust and reciprocity, fostering crime and violence, creating invidious social comparisons and damaging the family environment. Furthermore, an income gap is seen to reduce political activity and civic trust, leading to reduced welfare and human capital provision for the poor and dispossessed.

There are, however, a number of issues with the psychosocial interpretations of the contextual effects of income inequality which suggest the need to be circumspect about such conclusions. First, when compared to family or individual income the apparent effects of income inequality on health are quite small[190] (less than the impact of access to health services). Judge and Paterson, in their review of the income inequality debate, concluded that the effect of income inequality has been greatly exaggerated.[105]

Furthermore, the accurate measuring of contextual effects on health presents a formidable statistical challenge, raising questions about the accuracy of the generally modest effects that have been observed; for instance, income inequality may be measured in a number of different ways[191] which can yield different results. Another issue casting doubt on the hypothesis is that rising income inequality in some countries has been associated with falls in overall mortality rates (e.g. [177]) whereas, if the hypothesis were correct, the reverse would be expected. Theorists appear to have also generalised from circumstances that may be peculiar to the United States; studies in Canada[25] and Denmark[192] found no independent contextual effect on health for income inequality at a locational level.

Perhaps more problematic than US-centrism is the conclusion that social capital is the intermediary between income inequality and health outcomes. Inequality
2. The pathways between socio-economic inequality and health disadvantage

may well disrupt the social fabric, but it also has a wide range of other precursors and consequences that potentially affect health. The factors which create inequality and the 'wealth gap' are real differences in income, status and access to secure employment; for example, rising unemployment levels, increasing numbers of sole parents, reduction of wages and conditions for low income earners and the erosion of welfare provision (see Chapter 4). These observations have led to an alternative hypothesis, developed by neo-material theorists, that the impact of income inequality on health is related to differential levels of social investment and welfare provision, rather than the existence of a collective psychosocial burden.[102] (This line of argument is investigated more fully in Chapters 4 and 6.)

It may well be the case that the income inequality debate has now run out of steam, with two reviews of the literature concluding that the effect was essentially confined to the United States and 'barely discernable'.[105, 193] This led Judge and Patterson to conclude that "if poverty is properly addressed as a determinant of health, then income inequality per se should not be a concern for health policy makers."[105]p.40.

2.5 The neo-materialist position: an argument about fundamentals

An emphasis on the role of material factors in explaining health inequalities has a long history within public health. From early studies on sanitation and living and working conditions[70] to relatively more recent work,[51, 194] authors have firmly focused on the material and physical differences between rich and poor to explain the health inequalities between them. Now, in a world of unprecedented affluence and massive improvements in living and working
2. The pathways between socio-economic inequality and health disadvantage

conditions, the case for a material explanation has been substantially challenged by the argument that psychosocial factors such as stress and the relationships between people are more important determinants of health (see above). However, as has been discussed, the assertions for the superiority of psychosocial explanations have not gone unopposed; much of the critical response to the psychosocial position has taken the form of a restatement of the material position, termed neo-materialism (as outlined above).

The neo-materialist position has been articulated through a series of articles and books by a group of scholars, mainly from the United Kingdom.[27, 29, 73, 74, 101-103, 195] Along with a critique of psychosocial research and theory, their arguments have been supported through research demonstrating the links between particular material adversities (including inadequate investment in welfare and public goods), and poorer health. They have highlighted the very real material differences between socio-economic groups and the correlation of poor material standards with substantial mortality and morbidity differences, focusing on such facts as child poverty, and differences in car access, transport, education and employment.[27, 103] These theorists have also asserted the need for policies which address inequalities, arguing, for instance that a successful full employment policy in Britain would prevent 2% of avoidable deaths overall and 17% of avoidable deaths in areas of concentrated disadvantage.[29] They have also placed particular emphasis on the need for measures to redistribute of income and wealth more fairly.[103]

It is not surprising that the factors highlighted by the neo-materialist theorists are strongly associated with health; that is, markers of lower socio-economic status (e.g. unemployment and poor access to services) would be expected to correlate with poorer health outcomes. However, if our interest was in
determining what specifically causes health disadvantage these broad correlations may lack the necessary precision; for instance, when looking at the relationship between unemployment and health: is it the state of unemployment itself, the association with nutritional deficits and substandard housing, the stress caused by not having a job, or the increased likelihood of poor health behaviours which explains the poorer health of the unemployed?

Indeed, for a time it looked as though the debate between psychosocial and neo-materialist theorists would be about pathways – an argument over whether material or psychological adversity had a greater impact on health(see for example[195]). This type of debate is illustrated in one of the earlier attacks on the psychosocial position by neo-materialists: an analogy was used of business and economy class passengers, where the latter would feel worse at the end of the flight not because they are envious of those sitting at the front of the plane, but rather because they have been physically cramped and fed poorer quality food.[101] The point of this analogy is that psychosocial pathways were less plausibly damaging to health than real material differences between people.

The disagreement between neo-materialist and psychosocial theorists over causal pathways has also been reflected in the ongoing debate, discussed earlier, over whether absolute or relative income mattered most for health in affluent nations.[137] Whilst the neo-materialists appear to have won the income inequality debate, casting into doubt the impact of collective psychosocial factors on health, the evidence that psychosocial factors do affect individual health appears irrefutable. In fact neo-materialists now routinely acknowledge that psychosocial factors do have an effect,[27] but maintain that these factors should not be the focus of health inequalities research and intervention.
For neo-materialists, the key issue is contextual, lying with broader differences in the lives of socio-economic groups and the factors generating these differences, not the psychosocial mediators of the differences. Forbes and Wainwright sum up this view by identifying a 'so what factor': of course psychosocial factors have an impact on health, just as being hit be a truck will kill a person, but they ask:

What is important? Is it the relationship between the mass and velocity of the truck and its capacity to destroy body tissue or is it about: understanding where the truck has come from; why it is on that particular road and traveling at such a speed; or indeed, why someone is on that road at the time the truck is passing.[58]p.807.

Thus, the neo-materialist position has essentially become one about where to focus in the causal sequence between socio-economic inequality and poorer health; psychosocial factors may be part of the pathway but they are not where the real problem is located. Of course, once seen as a question of levels, the neo-material and the psychosocial positions are no longer directly incompatible; for example, Judge and Patterson cite Lynch as follows: "psychosocial and neo-material interpretations are not necessarily in conflict if psychosocial consequence of differences in neo-material living conditions are understood precisely as that – contextualised real world living conditions."(Lynch 2000 in [105] p21.)

2.6 Pathways to health through the life course

The next sections examine in more detail the ways in which exposures through the life-course can affect health, looking specifically at early life and two of the main determinants of socio-economic disadvantage: unemployment and sole parenthood. Discussing these factors illustrates the inter-relationship between
2. The pathways between socio-economic inequality and health disadvantage

psychosocial and material factors. It also shows how health inequalities are usefully understood from a life-course perspective, with accumulating exposures throughout life accounting for poorer health outcomes and reduced life expectancy.

2.6.1 Early life

Research into the possible impact of childhood experience on adult health inequalities has found a social gradient for a wide range of potentially damaging material and psychosocial factors.[151, 196, 197] Establishing the ways in which exposures in early life might damage or protect health is particularly important, given the growing popularity for early childhood interventions that aim to improve social and health outcomes.

There has been a long running debate in the general epidemiological and child development literatures concerning whether childhood – early life in particular – is of critical importance or not.[196, 198] That is, whether foetal and childhood exposures will affect long term health regardless of future circumstances (critical period model) or whether early life is just another period of life in which disadvantage may accumulate, and which is not necessarily more influential on health than adulthood exposures (accumulative model). The difference in view affects whether early life is seen as an essential intervention point or one which need not necessarily be favoured over other periods in the life course.

Within the health inequalities literature there is general agreement of the importance of childhood in relation to later health and well being;[199, 200] there is support for both critical period and accumulative views depending on which health outcome is being examined.[61] In general, too, even if early childhood is not seen as critical, early health adversity clearly puts a person at a
disadvantage in terms of increasing the lifetime likelihood of exposure to factors which damage health. Furthermore, early difficulties may make later ones harder to cope with; for example, having unresponsive parents in early childhood can make stress more difficult to cope with as an adult (see below). This type of understanding has led to the argument for the importance of intervening in the early years to avoid chains of risk.[198]

Even before a child is born it is likely to be affected by the low socio-economic status of its parents; for example, adverse differences in maternal diet, smoking, alcohol consumption and experiences of infection are all thought to influence foetal development.[197] Differential exposures persist through childhood in a low socio-economic status family, and adverse childhood circumstances have been independently associated with a range of health outcomes including mortality,[201, 202] morbidity,[201, 203] physiological risk factors (e.g. blood pressure, insulin resistance and obesity),[15, 204, 205] mental/emotional health[206, 207] and health behaviours.[203, 205, 206]

Conversely, higher socio-economic status not only reduces the likelihood of damaging exposures, it also, in some instances, appears to be protective of insults, enabling individuals to recover better from adversity; for example, children from more affluent backgrounds are less damaged by moderate lead poisoning and recover better from birth trauma than children of lower class.[196]

Psychosocial factors have been found to be of high importance in early life, with the quality of relationships between a child and their parents having long term implications for health. The most clearly adverse home environments are those in which children are abused or neglected, predisposing individuals later to a
The pathways between socio-economic inequality and health disadvantage

A wide range of physical and mental health problems and health damaging behaviours.[208, 209] However, more subtle deficits in parent child relationships can also adversely affect health and later coping ability.

Fonaghy argues that attachment theory is perhaps the most useful framework for understanding the impact of socio-economic inequality in early life on health outcomes.[16] The body of research produced in support of attachment theory has shown that the relationship a baby has with their primary carer has profound and enduring implications for well being. A carer relationship that is warm and responsive is more likely to result in a securely attached child; a relationship that is distant, inconsistent or punishing is more likely to result in an insecure attachment.[210, 211] Insecure attachment to a caregiver is associated with a range of possible increases in risk of disease in later life including altered stress physiology, increased use of substances to regulate mood, and diminished health protective behaviours.[212]

Research into early life attachment also illustrates the ways in which psychosocial and material determinants of health are intermeshed; the quality of parenting a person receives can affect their health as a child and adult and it is clear that parenting can only be understood in its social and economic context.[213] This is illustrated, for example, by research showing that economic stress is associated with the deterioration of parenting behaviour, leading to less sensitivity and more coercive parenting styles.[213, 214]

One of the most consistent observations in the health inequalities literature is the relationship between childhood and adult socio-economic status,[128] echoing a vast body of sociological research into the reproduction of class and socio-economic disadvantage (e.g. [215, 216]). This point has even been
2. The pathways between socio-economic inequality and health disadvantage

emphasised in studies in which the relationship between childhood circumstance and adult health has not proved significant.[138] As both adult and childhood socio-economic status have independent impacts on health, there is a clear need to understand the antecedents of socio-economic status, that is "the social and economic context in which individual life-courses are determined."[199]p.524. At this point in the literature, there has not been extensive engagement with the question of how socio-economic status is determined and maintained. This issue is returned to Chapters 4 and 6.

2.6.2 Unemployment and sole parenthood

Unemployment and sole parenthood, other than when of short duration, are both associated with low income and, hence, health disadvantage. There is also evidence to show that these states independently affect health: being unemployed or a sole parent can in itself damage a person's health. These states provide a good illustration of how occurrences at a societal and policy level can affect health; for example, through employment policies and welfare support. These themes are briefly touched on here and further developed in Chapters 4, 6 and 7.

Unemployment, particularly long term unemployment, has been linked with worse outcomes for physical health,[17] mortality,[217, 218] mental health[219] and health behaviours.[220] There is a risk to health even when relatively high levels of income support are provided; for instance, negative psychological effects for the unemployed are similar in Sweden to other countries with less generous unemployment benefits.[35] In addition, independent of income loss, experiencing unemployment carries a risk for health that may last for many years, even after a person is employed again.[221, 222]
2. The pathways between socio-economic inequality and health disadvantage

Unemployment is clearly related to economic and social context, with rates varying through the business cycle and some population groups being far more vulnerable to losing their jobs or to job market difficulties than others (see Chapters 4 and 6 for further discussion). Thus, although it is possible to understand unemployment simply as an assault on individual health, the magnitude of the problem and its fundamental causes lie at a societal level.

Sole parenthood is also strongly associated with low income and poorer health outcomes. Earlier in this chapter it was mentioned that sole parent status (for women) has been found to undermine health independent of income. Two studies comparing the health status of sole and married mothers in Britain with mothers in Sweden and Finland respectively observed this effect. Despite low levels of poverty and far more extensive social support in the Scandinavian countries, the health outcomes for sole mothers were still significantly worse than that of married mothers, when controlling for income. This manifestation is suggestive of psychosocial factors undermining health; for instance, loneliness and the stress of parenting alone. However, for the British mothers factors such as joblessness and poverty were far more predictive of worse health. Similarly, a comparative study of Norwegian and Canadian sole and married mothers found that differences in income explained differences in health outcomes; the researchers predicted that substantial health gains could be achieved for low income mothers in Canada by increasing welfare payments. The differential findings of these studies are indicative that both psychosocial and income related factors can have an independent impact on the health of sole mothers, with income related factors having a larger impact in nations with lower levels of government support for sole parents.
2. The pathways between socio-economic inequality and health disadvantage

2.6.3 Lifecourse approach

A lifecourse perspective is increasingly being presented as an optimal way for understanding the development of health inequalities.[61, 207, 227] This perspective sees health status as a consequence of accumulated factors during the different stages of life, rather than the outcome of factors present at a particular point in time. There is much evidence to support the lifecourse approach in the material discussed so far, and it is a logical approach given that many diseases are a result of long term exposures.

The lifecourse effect is well illustrated in studies which examine the effects of socio-economic mobility on health outcomes. People who are of a lower socio-economic status for their whole lifetime have worse health than those who achieve upward mobility as adults.[199, 201, 228] Those with the best health have been in an upper socio-economic status since childhood. However, the impact on health of low socio-economic status is not simply a matter of adding the number of negative exposures a person experiences in lifetime, as early adversity can make later adversity harder to manage. In other words, interactions between adverse circumstances as a child and adult are possible, leading to "higher mortality than would be expected on the basis of a simple multiplicative model."[201]p.43. Blane sums it up this way: "a person's biological status is a marker of their past social position and, through the structured nature of social processes, as liable to selective accumulation of future advantage and disadvantage." [229]p.64.

Hence, a lifecourse approach encompasses great complexity. It also suggests that interventions are unlikely to be greatly effective in reducing health disadvantage if targeted at remedying isolated adversities in a person's lifetime.
Thus, more general interventions, addressing the underlying causes of health disadvantage such as poverty and economic stress, may be more effective than singling out each of the adverse exposures and addressing them one by one. These ideas are developed further in the subsequent chapters.

2.7 Social and economic context

In the discussion of health inequalities it would appear inevitable that the wider question of what causes socio-economic inequality must arise at some point – just as one would expect those examining the impact of lead on child IQ in a lead producing town to turn their gaze to the local lead smelter. Therefore it could be expected that researchers would ask, what causes socio-economic inequality, and why are there health damaging differences in the experiences in the work and life of those of lower socio-economic status? Subsequently it might seem probable that researchers would ask, given the causes of socio-economic inequality, what can be done, if anything, about the problem of health inequalities? These types of questions are particularly to be expected due to the position of health inequalities research within public health, a discipline in which practitioners have long prided themselves on taking an 'upstream view' to health in contrast to the 'downstream' approach of biomedicine.[230] This perspective is reflected, for instance, in the public health parable that it is better to build a fence at the edge of the cliff, to stop people falling over it, than to fund more ambulances to rescue the injured bodies from the base.

It is indeed reasonably commonplace for health inequalities researchers to consider, or at least mention, the role of economic and social factors in creating health inequalities (as was observed in Chapter 1); for instance, societal factors such as a widening income gap or increasing job insecurity clearly have direct
2. The pathways between socio-economic inequality and health disadvantage

relevance to intermediate variables being studied. It is apparent that the 'upstream' for health inequalities is the socio-economic and political contexts including government policies in a wide range of spheres not directly related to health (e.g. transport, housing and early childhood). There is, however, a wide variance in the degree of engagement with socio-economic context by researchers, ranging from simply including socio-economic variables (e.g. [231]), to a brief mention of the relevance of structural factors (e.g. [11, 232]), to a more considered causal explanation (e.g. [26, 74, 233]. For example the issue of the impact of job insecurity on health might be understood and discussed at a range of levels:

- simply stated as a variable

- linked to increased job insecurity in society, and

- discussed in relation to the erosion of workers rights and connected to recent global changes.

On the whole, the vast majority of health inequalities research continues to demonstrate and explore the innumerable pathways between socio-economic status and health without grappling deeply with the underlying causes of the relationship. One of the main exceptions to this tendency has been apparent within the research and discussions of neo-materialist and psychosocial theorists, which have featured throughout this chapter. In fact one of the arguments between the two groups of theorists concerns the issue of wider context. The neo-materialist theorists have accused psychosocial theorists of de-contextualising health inequalities through focusing on the human psychological responses to inequality.[101] Psychosocial proponents have
countered the claim for the causal primacy high ground by arguing that they do (of course) see a need for addressing the contextual issues. [138, 186].

The following chapter considers in more detail the neo-materialist and psychosocial approach to socio-economic and political context. Although the discussion centres on their views, it should also be noted that other some other theorists have given serious consideration of these issues, including those from a Marxist perspective[51, 67, 68] and a core of non-aligned writers (e.g. [50, 233, 234]).

Of course, bringing context into the analysis raises a series of issues about what the term actually means. The biological and interceding pathways to health inequalities are themselves contested, but the disagreement about how to best explain society or the economic or political system are in another league entirely, as evidenced by decades long debates in the social sciences over these very issues.

2.8 Conclusions

From the above discussion of the health inequalities literature, a number of areas of general agreement can be discerned.

- There is a health gradient inversely related to socio-economic status.
- The poorest people in society have the largest health burden.
- Early life is an important period for determining health inequalities.
- The childhood determinants of adult socio-economic status can be considered as determinants of health.
2. The pathways between socio-economic inequality and health disadvantage

- The exposures which damage health accumulate throughout the life course.
- The underlying determinants of health inequalities are social, economic and political.
- Increasing wealth gaps are detrimental to health, and
- Income redistribution will probably benefit health.

Despite these general areas of agreement, it is still not possible to be completely precise about what causes health inequalities in general or the health disadvantage of the poorest groups in society. This is because health is damaged by complex and interacting exposures to psychological, social and material factors over time, and these exposures differ and have different impacts depending on who is being studied, as reflected, for instance, by the range of values arrived at by different studies for the same outcome (e.g. work stress or health behaviours). Also, exposures will vary by other factors such as country of origin, culture, gender and race, as illustrated, for example, by the contrasting experiences of sole parents in different countries. The question arises of where this complexity leaves those interested in reducing the problems of health inequalities and health disadvantage, for whom a more certain causal framework would be useful.

First, it seems appropriate to question the inclusion in a causal framework factors which have been shown to have a very small or uncertain impact on health. This notion would suggest the need to abandon further discussion of the income inequality(collective social capital question. It could also be suggested that there is not great value to be had in focusing research attention on either the
health impact of reverse causality or measures of individual social capital as explanations for health disadvantage.

Moving on to which factors are important, there is a definite logic to the neo-materialist position: given that health inequalities are a consequence of the wider social and economic context, it makes sense to focus at this level of analysis rather than on the mediators (e.g. stress, control at work) between socio-economic structure and health. However, the discussion in this chapter also suggests that psychosocial factors may need to be addressed in their own right: they clearly have an impact on health and cannot necessarily be fixed just by addressing the material difference between people, (e.g. a psychosocial burden could still occur as a consequence of working in boring repetitive jobs or of being a sole parent). Overall, unless we are able to eliminate the inherent stresses of certain life conditions and social hierarchies altogether, psychosocial factors may be expected to continue to undermine health.

Reducing income inequality seems likely to impact positively on both material and psychosocial factors, even if an income gap is not miasmic in itself. Reducing absolute deprivation could be expected to concurrently reduce relative deprivation. However, the question of whether reducing income inequality is an issue of raising the living standards of the poorest groups in society or simply narrowing the income gap by whatever means, is indicative of the differences of view in the psychosocial and neo-materialist positions. These issues are returned to in the next chapter.

It would also appear to make sense for an explanatory framework to highlight those factors which have the greatest impact on health inequalities: health behaviours stand out in particular. However, as the discussion illustrates, this is
no straightforward matter. Not only does the impact of different factors vary quite markedly across studies, but factors considered in isolation of context can only give a partial picture. The latter issue is well illustrated within health behaviours, with both neo-materialist and psychosocial theorists understanding that, at least to some extent, people develop health damaging behaviours in response to the pressures in their environment.

There is also a case for emphasising early life, given its position in cascading chains of disadvantage and risk. Lifelong health can be affected by exposures in this time, and it is also a period that strongly influences adult socio-economic status. Here, too, is great complexity, with the disadvantages accumulated by children both resulting from the family setting and also the context in which that family lives. Is the real problem, for instance, the breakdown of parenting or the long term unemployment which preceded it?

Finally, there are some areas with apparent importance that have yet to be investigated fully, in particular the effects of qualitative differences in health services and the possible buffering effects they might provide.

Overall, a number of conclusions might be drawn from this vast body of research. In essence, being socio-economically disadvantaged is bad for health due to the myriad of exposures that accompanies this state. The largest component of these exposures is likely to be health behaviours, with the rest comprised of a diffuse array of small material deficits and psychological assaults which begin in the pre-natal environment. Furthermore, particular states associated with socio-economic disadvantage, such as unemployment and sole parenthood, have a negative impact on health. None of these factors can be meaningfully understood without attention to the context in which they occur:
2. The pathways between socio-economic inequality and health disadvantage

both the socio-economic hierarchy and the processes which make the experience of living and working at the bottom of this hierarchy very different to living and working at its top.

It has been suggested that perhaps it is time to stop investigated the pathways to health inequality and to start looking for solutions to the problem.[235] A cursory glance at the ever burgeoning health inequalities literature indicates that this advice will probably remain unheeded, at least for some years. However, leaving this data to accumulate as it may, the question this research now turns to is: given what is known about the causes of health inequalities, what, if anything, can be done to resolve them?
3. Can the problem of health disadvantage be solved or reduced?

3  Can the problem of health disadvantage be solved or reduced?

3.1 Introduction

The previous chapter explored the ways in which health inequalities resulted from socio-economic inequalities. It was concluded that low socio-economic status across the lifecourse increases exposure to health damaging material deficits, psychosocial stresses and the likelihood of health damaging behavior. Health inequalities can be understood, then, as the embodiment of economic and social inequalities, with socio-economically disadvantaged people also suffering a distinct health disadvantage. The logical question arising from this understanding is: what, if anything, can be done to solve or reduce these problems (health inequalities in general and health disadvantage in particular)? These issues are the focus of this chapter, which specifically examines:

- whether health inequalities and health disadvantage are theoretically solvable or reducible problems
- approaches that have been proposed to reduce health inequalities/disadvantage
- the feasibility of these approaches, in theory and practice, and
- what issues need to be examined to understand the barriers to potential approaches.

Discussing these issues is a necessary step in investigating the thesis aim of exploring the potential of a locational approach to reduce health disadvantage. In the first instance, and at the risk of stating the obvious, there is little point in
3. Can the problem of health disadvantage be solved or reduced?

attempting to reduce health disadvantage if it is not actually possible to do so (at a locational level or otherwise). Examining the approaches proposed by psychosocial and neo-materialist theorists to reduce health inequalities/disadvantage is also important: it indicates some of the options available to address the problem and provides points of comparison from which to consider a potential locational approach (are there, for instance, better approaches available?) The approaches are first considered in the light of the evidence base developed in Chapter 2, to determine if they are directed at the established causes of the problem of health inequalities/disadvantage. The issue of whether these approaches would face political opposition is then raised; the argument is made that if proposals are to be practical it is necessary to give due consideration to the prevailing political and economic context.

This chapter is largely a theoretical discussion, in that it does not discuss actual policies or interventions in detail (this is undertaken in Chapter 7). Rather, the focus is on the proposed approaches to reduce health inequalities/disadvantage that have been developed by psychosocial and neo-materialist theorists. In view of what they have proposed, the questions are asked: 'if we did X, could Y be expected to happen?', and 'is doing X actually possible?' (Also, as discussed in Chapter 1, the term 'approach' is used to refer to the overall direction taken to an issue, in practice it may involve a wide number of policies and interventions. Income redistribution, for instance, is an approach designed to reduce health inequalities/disadvantage – an approach which could be achieved by a variety of measures including taxation reform, welfare payment increases or locational based subsidies.)
3. Can the problem of health disadvantage be solved or reduced?

3.2 Framing the problem

The health inequalities literature has so far largely concentrated on documenting and explaining the health gradient in populations. There has been far less attention devoted to developing and evaluating appropriate approaches, policy responses and interventions to address health inequalities and/or health disadvantage.\[13, 14\] This predisposition is perhaps to be expected, given the degree of uncertainty about all the factors involved in translating lower socio-economic status and its correlates into poorer health. Thus, although it is possible to say with great certainty that exposure to the factors associated with socio-economic disadvantage across a lifetime increases a person's chances of an early death and excess morbidity, it is much more difficult to isolate all the factors contributing to such an outcome. Chapter 2 showed that socio-economic disadvantage is correlated with a multitude of health damaging impacts from the pre-natal period, through childhood and into adulthood. However, each person may experience a different 'package' of impacts, with health damaging factors varying, for instance, between societies, historical periods and genders. Furthermore, states that usually (but not inevitably), lead to socio-economic disadvantage may be independently damaging to health: in particular, unemployment and sole parenthood. Therefore, any response to the problems of health inequalities/disadvantage needs to deal with enormous complexity.

The question is, then, from respective psychosocial and neo-materialist positions, is it hypothetically possible to eliminate health inequalities (and thereby health disadvantage) so that differences in health and mortality outcomes are distributed randomly through socio-economic status groups?

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5 As explained in Chapter 1, 'health disadvantage' refers to the excess morbidity and mortality suffered by socio-economically disadvantaged people (approximately the lowest 25%-30% of income earners), whereas 'health inequalities' refers to the gradient of unequal health outcomes across the population.
3. Can the problem of health disadvantage be solved or reduced?

3.2.1 The psychosocial understanding

The logical conclusion of the psychosocial position is that health inequalities can be greatly reduced but differences in health will exist in some form as long there is a social hierarchy. In a capitalist society, income acts as a proxy for social status therefore health inequalities have come to be correlated with income. However, if society were ordered on some other basis, say as in animal primate societies, then health inequalities would be correlated with that other factor: for example, if human hierarchies existed on the basis of physical strength. Marmot has suggested that as humans have always had social hierarchies then so too are health inequalities part of the natural order.[93, 236] In the view of psychosocial theorists, the present problem of health inequalities is created because income differences artificially inflate the social hierarchy and create a psychosocial burden on health for all except the very rich.[26, 93] Narrowing the income gap would thus be expected to reduce health inequalities/disadvantage: "health status for everyone can improve, and the slope of the gradient can change"[93]p.S12: health inequalities can be reduced but not completely eliminated.

3.2.2 The neo-materialist understanding

The hypothetical end point for neo-materialists is more optimistic than that of the psychosocial theorists. Given the position that health inequalities are a result of material differences between people along with systemic underinvestment in human services and infrastructure, the possibility exists that the problem might be eliminated. Even at the upper end of the socio-economic status hierarchy – the point at which psychosocial theorists have emphasised the role of psychosocial factors – neo-materialists still see a role for material factors: "there is evidence that health is sensitive to fine gradations of material conditions
3. Can the problem of health disadvantage be solved or reduced?

within wealthy countries, as evidenced through living in better neighbourhoods, access to a car, home ownership, and having a home with a garden."

Thus, it can be extrapolated from the neo-materialist position that if material differences between people were removed and access to services did not vary by socio-economic status then the problem of health inequalities/disadvantage could theoretically be eliminated.

3.2.3 Proposed approaches

Despite apparently quite different theoretical endpoints, proponents of the two different positions have tended to argue for similar approaches to reduce health inequalities/disadvantage, namely:

- reducing income inequality through income redistribution, and
- a series of interventions targeted at improving the social and material well being of the most disadvantaged groups in society.

Where the differences between the two positions are apparent is in the supporting rationales. Psychosocial theorists argue that psychosocial benefits will accrue from what they advocate (e.g. that the approaches will improve social cohesion and reduce stress);[26, 30, 138] neo-materialists, by comparison, focus firmly on the resulting material benefits and reduction in poverty.[27, 101, 103, 195]

3.3 What approach to use?

3.3.1 Narrowing the income and wealth gap

Income redistribution can take many forms, including increasing the incomes of the poor or reducing the incomes of the rich, or both. Psychosocial theorists tend
3. Can the problem of health disadvantage be solved or reduced?

to discuss income redistribution in general terms, for instance, the need to reduce the 'scale of income differences in society'.[26] In contrast the neo-materialists have explicitly stated the need for wealth to be drawn from the rich and redistributed to the poor.[103] This section considers whether income redistribution, as perceived by psychosocial and neo-materialist theorists respectively, is a rational proposal for reducing health inequalities/disadvantage.

The way income is distributed in society is a theoretical preoccupation for psychosocial theorists. The concept is fundamental to Wilkinson's relative deprivation hypothesis: what matters for health is not so much per capita income but how it is distributed. Thus, raising lower incomes or reducing higher ones will benefit health through reducing the aggregate psychosocial burden created by being deprived in relation to one's fellow citizens. Complementing the relative deprivation theory is the idea that a narrower income gap has a collective benefit for all citizens in society.[16] This notion of a collective benefit is apparent in Kawachi and colleagues' collective social capital theory: income divisions in a society erode the trust and connectedness between people, potentially affecting the health of the entire population: a more income equal society is more trusting and cohesive, and hence healthier.[173, 188, 189]

The purpose of reducing income inequality is therefore the benefit it will bring to social relations, enhanced moral collectivity and collective purpose, not increased access to goods and services; "it is the social feelings which matter, not exposure to a supposedly toxic material environment."[26]p.213. Focusing on the wealth gap rather than the material well being of the poor implies that the health of the poor can be improved even if their incomes are not increased: say, for instance, if the middle and upper classes are taxed more heavily.
3. Can the problem of health disadvantage be solved or reduced?

As might be predicted, neo-materialist theorists have focused on the material benefits of poverty alleviation through redistributing incomes and wealth, rather than the 'social feelings' and diffuse, population-wide psychosocial benefits. For the neo-materialists, reducing health inequalities is a straightforward question of reducing poverty – the answer to which is equally straightforward: "the poor have too little money and the solution to ending their poverty is to provide them with more money."[103]p.191. They call for a minimum guaranteed income for all citizens regardless of circumstances. The extra money for the poor is to come from the wealthy and middle classes, so that incomes might be raised and welfare payments increased, and through subsided in kind services (e.g. education, health or transportation)[103] Thus, in essence, the neo-materialists are actually focusing on reducing the health disadvantage of the poor rather than the health inequalities which affect most of the population.

On the basis of the available evidence (as discussed in Chapter 2), redistributing income can be expected to improve health. However (recalling the conclusions of Chapter 2), there is insufficient evidence that this, should it occur, would be for the reasons asserted by Kawachi and colleagues. That is, the theory that income inequality damages health through reducing social cohesion and collective measures of social capital does not hold outside the United States (and quite possibly not within the USA – that is, the income inequality/health relationship could be caused by other factors). With regard to Wilkinson, there is evidence to suggest that hypothesised improvements in health could be, at least partially, from the rationale he asserts: a more equitable income distribution could reduce relative deprivation, thereby reducing psychosocial stress and hence allow health to improve. Similarly, there is evidence to support
3. Can the problem of health disadvantage be solved or reduced?

the arguments of the neo-materialist theorists' position on income redistribution, providing it involves raising the incomes of the poor: improved material well being of socio-economically disadvantaged people should improve their health. Income redistribution thus has theoretical benefits to health through reducing both material and psychosocial factors which have been shown to damage health. Income redistribution by itself cannot, even theoretically, entirely remove the problem of health inequalities. Raising lower incomes (either relatively or absolutely) will not deal with a wide range of psychosocial stresses which are not a function of income but which tend to be experienced more intensely by lower income earners; for example, work issues shown to be associated with poorer health outcomes such as jobs which are boring, unsatisfying and lacking in autonomy (see for example[97, 152]). These issues can really only be resolved by changing the way work is organised in different enterprises. Other issues, such as the isolation of older people and the lack of support for new parents, would also appear to require solutions beyond raising incomes. The next section considers some of the other proposals for reducing health inequalities/disadvantage.

3.3.2 Policies to alleviate socio-economic and health disadvantage

Aside from measures to create income redistribution, a range of policy suggestions to address health inequalities/disadvantage have been put forward by psychosocial and neo-materialist researchers.([27, 103, 139, 143, 236, 237]) In this section these policies are grouped into four categories according to their general theme – categories which can broadly be understood as 'approaches'. These are discussed briefly here to give an overview of the kinds of policies and
3. Can the problem of health disadvantage be solved or reduced?

approaches that could be adopted to reduce health inequalities/disadvantage in addition to, or in place of, income redistribution. The approaches are as follows:

1) policies to benefit the material and psychosocial well being of socio-economically disadvantaged people (e.g. the provision of free or subsidised in kind services to low income earners such as housing, health education, transport).

2) social policies to address the causes of socio-economic disadvantage (e.g. employment creation, job training and reducing early school leaving).

3) social and employment equity policies (e.g. protecting the rights of workers, promoting human rights).

4) policies to reduce the impact of socio-economic disadvantage and income inequality on health (e.g. early intervention with socio-economically disadvantaged families, extra health services and targeted health promotion aimed at socio-economically disadvantaged people).

The first of these approaches constitutes *de facto* income redistribution, in which the real incomes of the socio-economically disadvantaged are increased through the provision of low cost or in kind goods and services (e.g. health care, housing, education, transport, etc). Clearly, if these services were provided more widely and restricted to socio-economically disadvantaged people it would provide a means of income redistribution (and reducing health disadvantage) that might be more politically palatable than a major reworking of the tax system.[103] It is also possible that in kind services can protect health in their own right: it has been argued that the provision of these types of services is the reason why some countries with a high degree of income inequality do not have the depth of health inequalities that might be expected.[25]
3. Can the problem of health disadvantage be solved or reduced?

The second approach comprises policies aimed at the causes of socio-economic disadvantage. In general, the issues to be addressed by such policies do not relate directly to health but are important determinants of health inequalities and health disadvantage (in particular). They include policies aimed at employment creation, improved school retention and reducing teenage parenthood. Policies of this nature are central parts of endeavours in Europe to address social exclusion.[39] However, their effectiveness in reducing health inequalities has yet to be determined, although it seems probable that if they were successful in addressing socio-economic disadvantage they would also reduce the health disadvantage.

The third approach pertains to the promotion of equity, rights and justice and has mainly been advocated by psychosocial theorists.[139] It includes, for example, policies to change work conditions and hierarchies and policies to protect the rights of the homeless and refugees. It is uncertain whether any government has implemented policies of this nature in order to promote health.

Policies comprising the last approach do not aim to address the causes of socio-economic inequalities but rather to reduce the impact of socio-economic disadvantage on health. In practice, most policies and interventions to reduce health inequalities/disadvantage have been or are of this nature. Notable examples include policies to support the development of young children in disadvantaged families and health promotion focused in disadvantaged locations or with particular sub-populations (e.g. the homeless, drug addicted or teenage mothers).[238-240]
3. Can the problem of health disadvantage be solved or reduced?

3.3.3 Addressing cause or effect?

Geronimus distinguishes between approaches to reducing health inequalities in terms of fundamental and ameliorative acts.[66] Fundamental acts work to change the socio-economic inequality which underlies health inequality. In contrast, ameliorative acts are aimed at the risk factors that link socio-economic inequality to health but do not fundamentally alter the underlying socio-economic inequality (e.g. early childhood intervention or reducing obesity in low income populations). The distinction between fundamental and ameliorative acts (see Figure 3) can be applied to the approaches described above. Approaches 2 and 3 involve policies which are aimed at addressing the fundamental causes of health inequalities, being directed at the economic, social or political realm (Box A, Figure 3). By contrast, approaches 1 and 4 involve policies which aim to ameliorate the effects of socio-economic factors on health. (Box B, Figure 3).

**Figure 3. Causal pathways to health disadvantage.**

<table>
<thead>
<tr>
<th>A</th>
<th>Fundamental causes of health disadvantage (e.g. Socio-economic inequality, socio-economic disadvantage and unequal rights)</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Effects of socio-economic inequality and socio-economic disadvantage (e.g. early life disadvantage, poor housing, inadequate health services)</td>
</tr>
<tr>
<td>C</td>
<td>Health Disadvantage</td>
</tr>
</tbody>
</table>
3. Can the problem of health disadvantage be solved or reduced?

The discussion in this chapter has shown that psychosocial and neo-materialist researchers agree that there is a need to focus on fundamental approaches (Box A), even if there is in practice an obligation to work to reduce the effects of socio-economic inequality on health (Box B). Wilkinson states that health inequalities cannot be addressed by skipping the egalitarianism and moving straight to social reforms; his view is that rather than providing more special needs classes, more prisons, more social workers and health services we need to tackle the root causes of these problems.[26] Similarly, as discussed earlier in this chapter, the neo-materialists do not have a great deal of patience for ameliorative actions when the real causes of health inequalities/health disadvantage are so clear.[103]

3.4 How could the proposed approaches be achieved?

Having examined some possible approaches for addressing health inequalities/health disadvantage, the next questions that arise are:

- How could these approaches be implemented?
- Would governments actually implement these approaches?

The latter question raises a particularly pertinent issue, given that the pursuit of income equity and increased spending on social and other services clearly face substantial challenges in the US, the UK and Australia, all of which have experienced increasing income inequality, declining welfare provision and disinvestment in public infrastructure in recent decades.[31, 33, 241]

For psychosocial theorists, reducing health inequalities/disadvantage must involve a political commitment to social justice.[16, 242] This argument is made by Daniels and colleagues, who assert that the essence of improved population
3. Can the problem of health disadvantage be solved or reduced?

health lies with 'justice', rather than more spending on the health system.\textsuperscript{139}\textsuperscript{6}

Drawing from liberal philosopher John Rawls, they argue for: ‘equal liberties, robust equal opportunity, a fair distribution of resources and support for self respect’. Implementing these ideals would involve the government in ensuring equality of access to health care and basic education, healthy workplaces and equality of political participation.

Wilkinson takes a similar line to his American colleagues but is more specific about how an equitable society might be achieved, taking particular issue with the economic rationalist arguments that equity can only be ‘afforded’ at a particular level of economic prosperity. He points out that inequality has substantial social and economic costs, with more unequal societies experiencing slower growth, a costly welfare burden and a huge waste of human resources. Wilkinson is confident that once this contradiction becomes apparent to governments political will be generated sufficient to create a more equitable distribution of resources. Furthermore, he argues that employers' economic interests are served by providing well paid secure work to their employees, and that mutual co-operation rather than antagonism should be pursued.\textsuperscript{26}

From a political economy perspective on health, Wilkinson's analysis appears problematic. The argument that the cost of inequality is a 'cost we incur for no economic benefit'\textsuperscript{26}p.230 does not recognise that increased economic inequality has, over the past decades, been associated with large increases in the incomes and wealth of the most advantaged socio-economic status groups in the UK, US and Australia.\textsuperscript{241, 243} In addition, productivity may indeed be enhanced by having a well paid and well treated workforce, but employers also

\textsuperscript{6} The authors make this distinction because there is still a commonly held that the issue of 'health' actually means 'health services'.

111
3. Can the problem of health disadvantage be solved or reduced?

clearly benefit from an insecure and lowly paid workforce, particularly industries employing large numbers of low skilled and easily replaced workers. These issues are discussed in more detail in the next chapter.

The neo-materialists present a stronger analysis than the 'inherent good sense' case of the psychosocial theorists. They argue that the desire of governments to be re-elected is a persuasive counterforce to the tendency for politicians only to serve the needs of the most powerful groups in a democratic society.[103]

Through documenting the actual amount of public support for different equity measures in Britain, Shaw and colleagues are able to show that there is both strong public support for governments (or at least for the British government) to eliminate poverty and reasonable support for a minor increase in taxes to achieve this end; acceptance, for instance, of a measure demonstrably as small as increasing taxes by one pence in the pound could save thousands of lives and substantially reduce the disease burden of Britain’s poorest citizens.[103]

The neo-materialist case, despite being compelling, also fails in practice. There may well be strong support for the neo-materialists' suggestions but the Blair Labour Government has not implemented such measures during its years in office, despite an official inquiry into health inequalities[244] which strongly recommended government action on the problem. This fact does not escape Shaw and colleagues' attention and they have developed a detailed critique of their government’s failure to deliver policies which could reduce health inequalities/disadvantage.[103] In this critique they convey a sense of deep disappointment, as the initial commitments of the government and their positions stated in opposition have given way to 'practical politics' and to 'keeping the markets happy'. In Shaw and colleagues' view, aims to eliminate child poverty, redistribute wealth and establish clear goals to reduce health
3. Can the problem of health disadvantage be solved or reduced?

Inequalities/disadvantage have been replaced gradually by interventions targeting individual behaviour change and under-funded locational interventions: national targets on health inequalities have been translated into national targets on reducing the incidence of specific diseases in the whole population. They also take particular issue with their government’s use of a locational approach to address health disadvantage because they believe that this serves to undermine the essential policy of income redistribution. That is, a locational approach is a way of appearing to do something about health inequalities/disadvantage which is far less costly or politically risky than increasing taxes on upper income groups.[27, 103]

3.5 The need to identify the deeper causes of health inequalities/health disadvantage

The discussion so far indicates that governments are largely either unwilling or unable to do what is necessary to address the inequities which underlie health inequalities. This suggests that there are deeper causes of the problem that need to be understood – if what the theorists argue is evidence-based and rational, why is that governments are not following their advice?

Coburn argues that explaining health inequalities must involve a discussion of contemporary political discourses and styles of government in western societies.[69] He criticises psychosocial theorists for focusing too extensively on income inequality as the cause of health inequalities and ignoring a gamut of underlying political and economic determinants of the income divide. He sees it that an adherence to neo-liberal philosophies by western governments is particularly influential in maintaining social and economic divisions: the
3. Can the problem of health disadvantage be solved or reduced?

dominance of market and user pays principles and reduced welfare spending act to reinforce and widen health and income gaps between rich and poor. In addition, Coburn points out that neo-liberalist policies explain the links between greater income inequality and the reduction of in kind services seen in some nations.[69, 245]

In a response to Coburn, Wilkinson argued that psychosocial theories are concerned with explaining the effects of relative deprivation and income inequality rather than the era-specific factors associated with the present political climate. Concentrating on neo-liberalism, argues Wilkinson, "merely limits the theory to a historically specific instance: widening income differences seem likely to be damaging, almost whatever their source."[186]p.998.

Wilkinson's argument may well be borne out in time; however, if our concern is with identifying and addressing a problem in the present it could be argued that it is imperative to recognise the contemporary dimensions of that problem.

If this argument is accepted, it is necessary to have an understanding of the current political and economic systems and an explanation of the creation of socio-economic inequalities between groups of people in society. It is also necessary to identify both who benefits from a divided society and the prevailing political ideologies which can justify or, alternatively, oppose or ameliorate the divide; for instance, to be able to identify what influences taxation and welfare spending decisions in a society and to recognise when a government is enacting policies that actually increase socio-economic inequality. Indeed, if our interest is in reducing health inequalities and disadvantage rather than just documenting and lamenting the problems, issues of this nature must be coherently addressed, if only for no other reason than to show the limitations of ameliorative approaches that might be developed. For Wilkinson, who does
3. Can the problem of health disadvantage be solved or reduced?

not have such an analysis, continuing socio-economic inequality is inexplicable: not only does the phenomenon undermine health, it also damages the social fabric and economic prosperity.[26] Similarly, Shaw and colleagues appear surprised that their very sensible suggestions create such little interest.[103]

3.6 Conclusions

This chapter has discussed:

- whether health inequalities/disadvantage can be eliminated or reduced, and
- given this, how the reduction of health inequalities/disadvantage could be achieved.

There is a consensus among both psychosocial and neo-materialist researchers that health inequalities/disadvantage are reducible problems. Proponents of both positions argue for a need to address the fundamental cause of health inequalities: namely socio-economic inequality. Equity, they argue, is best achieved by income redistribution. Although income redistribution is viewed as the optimal approach, researchers have also argued for other measures to address the problem. These include policies to assist the socio-economically disadvantaged to improve their employment and incomes, the provision of in kind services (to lift real incomes) and the promotion of social equity and justice.

However, the question of how these policies might be implemented has not been well addressed. Researchers from both camps drift into idealistic and persuasive arguments, rather than identifying the exact limitations on their suggestions. The substantial lack of political will to pursue the recommended approaches has largely been ignored by the psychosocial theorists (particularly
3. Can the problem of health disadvantage be solved or reduced?

in the US) and is a source of profound disappointment for the British-based neo-
materialists.

In order to determine the barriers to achieving health equity it was argued that
there needs to be recognition of both the contemporary causes of socio-economic
inequality and the political discourses that sustain socio-economic inequity. It is
at this level that the problem of health inequalities/disadvantage originates and
is sustained. Recognising the limitations these ‘macro factors’ pose, whilst
perhaps somewhat sobering, does open the way to start considering the
possibilities offered by alternative approaches to reducing health disadvantage –
such as a locational approach.

Indeed, although this chapter has centred on the wider issues of how health
inequalities and health disadvantage might be addressed, there are a number of
implications (arising from the discussion) for a locational approach to reduce
health disadvantage. Foremost, it is clear that when it comes to health
disadvantage there are limitations on what can be achieved through a locational
approach. Most of the suggested measures to overcome health
inequalities/disadvantage would need to be applied at a population level.
Income redistribution, for example, would require national policies to adjust
taxation, welfare and minimum wages. Similarly, improving social equity and
human rights would require national or state legislation – these issues cannot be
addressed on a locational basis. The policy of providing subsidised in kind
services, if it is to effectively redistribute population income, must also be
applied to all health disadvantaged people regardless of where they live
(although in kind services could be provided on a purely locational basis); the
effectiveness of this policy would be dependent on how many socio-
economically disadvantaged people were concentrated in these locations.
3. Can the problem of health disadvantage be solved or reduced?

In terms of the more positive possibilities implied for a locational approach: alleviating socio-economic disadvantage through labour market, educational and other interventions could potentially occur on a locational basis; for example, through location based employment and schooling interventions. Similarly, reducing the impact of socio-economic disadvantage on health could conceivably occur as part of a locational approach; for example, by programs in disadvantaged schools and early intervention work with families in disadvantaged locations.

What, then, to make of the neo-materialist critique that a locational approach to address health disadvantage obfuscates what is really necessary to address the problem (namely income redistribution)? This issue is returned to in Chapter 7 but, for present purposes and in regard to the Australian situation, it is important to note that the current Australian government has also been reluctant to pursue income redistribution and the income and wealth gap continues to widen.[243] This reluctance indicates that there is a need to find alternative approaches (such as those in the categories listed above) to address health disadvantage, and also to accept that the redistribution solution is not feasible at this time.

Finally, to reflect on what the British experience with health inequalities might mean for Australia: on the positive side, governments can be persuaded to attempt to reduce health disadvantage, even if it is in a piecemeal, *ad hoc* and politically expedient fashion. Less optimistically, it can be concluded that the barriers to reducing health disadvantage are probably far greater and more politically sourced than many imagine. It is to these issues that the discussion now turns.
4 Social exclusion: a framework for understanding health disadvantage.

4.1 Introduction

In the previous chapters the case was made for developing a conceptual framework for understanding the causes and dimensions of social and economic inequality. This process, it was argued, is an essential step in recognising both the underlying causes of health disadvantage and the many barriers to addressing this problem – including through a locational approach. In this chapter the conceptual usefulness of 'social exclusion' is established, both as a descriptor of the most socio-economically and health disadvantaged in society and as a concept which captures the processes which create and maintain such disadvantages, including those which exist at a locational level.

This chapter defines social exclusion, identifies its theoretical context and outlines its socio-economic and locational dimensions and its relationship to other social stratifications. It is argued that poverty and structural unemployment are the factors which generate social exclusion, and also that income polarisation and policies of economic deregulation have exacerbated exclusionary processes. The discussion in this chapter centres on how social exclusion operates in the affluent world; Chapter 6 examines in more detail how social exclusion is manifested in Australia. There are numerous understandings of social exclusion; the perspective presented here draws mainly from the critical social science/neo-Marxist influenced version of social exclusion.[246]
4.2 What is social exclusion?

The term 'social exclusion' originated in France over twenty years ago and is in common use in countries of the European Union[247] and in Canada.[248] It is a policy concern of the European Council, and in England addressing the problem has become central to the Blair Labour Government's efforts to reduce poverty, unemployment and other social problems. [249-254] In Australia, 'social exclusion' has featured more prominently in economic and social policy research and debate.[255, 256] Its use is increasing within social theory, with some writers finding it preferable to the more pejorative 'underclass'.[257] The term is slippery and contested and has been used both interchangeably with and in conjunction with a number of other descriptors of socio-economic disadvantage such as poverty, marginalisation and deprivation.[247, 258]

Social exclusion has been defined by reference to the conditions experienced by excluded populations, for instance: "Social exclusion is a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low income, poor housing, high crime environment, bad health and family breakdown."[252]p.8.

Alternatively, social exclusion can be defined by referring to its causes, for example: "Social exclusion is a set of processes, including within the labour market and welfare system, by which individuals, households, communities or even whole social groups are pushed towards or kept at the margins of society." (Northern Ireland, Democratic Dialogue in [259]p.26).

It appears that the term is most usefully employed as including simultaneously descriptive and causal aspects; if social exclusion is abstracted from its causal processes, it risks becoming a descriptor of disadvantage not necessarily more
useful than existing terms (e.g. multiple deprivation) or, alternatively and unhelpfully, an endogenous problem with no apparent causes. Most writers on social exclusion, whether in the realms of policy or theory, do in fact recognise that if there are excluded people there must also be 'something' which creates exclusion, even if they disagree about the causes of social exclusion and the degree of intent involved. Thus social exclusion is usually understood as a dynamic concept,[247, 257] resulting from societal processes rather than comprising only a list of disadvantages and problems. Even organisations which define the concept descriptively (e.g. the British Social Exclusion Unit – see above) usually consider the causes elsewhere in their discussions and/or policy documents.[252]

Social exclusion is also a relative concept based on norms in a particular nation: the included have what the excluded do not, but only in that specific society. In this sense, social exclusion has useful parallels with the concept of relative deprivation developed by psychosocial theorists within the health inequalities literature (it was established in Chapter 2 that, according to the psychosocial perspective being deprived in relation to others in one's society creates a burden for health). Similar to relative deprivation, there are difficulties with using the term comparatively across nations; for instance, comparing levels of social exclusion across the member states of the European Union would be complicated by differing living standards: a poor person in Luxembourg might be considered middle class in Portugal.

Fittingly, too, for research centering on affluent nations, the term social exclusion is generally applied to the advanced industrialised nations of Europe, United States, Japan, Canada, Australia and New Zealand; clearly, most of the 'excluded' in these societies are, in material terms, substantially better than the
majority of the world’s population. Even so, social exclusion is creating deep concern in the affluent world for a wide range of reasons, including welfare cost blowouts, fear of civil unrest, a growing underclass of generational unemployed, fractured communities and a lack of social justice and equity.[252, 260-262]

Although it is not actually possible to precisely quantify the numbers of people who are affected by social exclusion in a nation, Byrne estimates that people in the bottom quartile of incomes in a population could be placed in this category.[246] In the UK this accords quite closely with the number of people who consider themselves to be in relative poverty,[263] and in Australia upper estimates by some organisations approach a quarter of the population[264] (although estimates based on an inability to afford basic necessities are closer to 5%[265]). Precision is difficult because an income that may cause exclusion for one person may not for another: say, for example, if they also have access to affordable housing and services. Countries with strong social and income support for low income earners would tend to have less social exclusion than those countries with weaker state support (e.g. Finland,[266] Germany and Sweden[267]). Additionally, social exclusion is a dynamic state which people can move in and out of across the life course, particularly if they are only able to secure periodic paid employment. Classifying which people can be considered socially excluded is discussed in more length throughout this chapter.

4.2.1 Definition used in this research

There are many ways of defining social exclusion, so when using the term it is necessary to be clear about what is meant. For the purposes of this research, social exclusion is defined as: the processes, policies and actions which create
socio-economic disadvantage and 'shut out' groups of people from the opportunities and benefits enjoyed by the majority in a particular society. Underwritten by relative poverty, the dimensions of exclusion include employment, social participation, and choices around location, education, and services. Furthermore, "deprivation along these dimensions can, in combination create acute forms of exclusion that find a spatial manifestation in particular neighbourhoods."[247] p.22

This definition contains both descriptive and causal elements. Theoretically, the definition draws from a critical social science perspective in which relative poverty is viewed as the basis of social exclusion.[268] 'Relative poverty' in this case follows Townsend's definition: "individuals, families and groups can be said to be in poverty when their resources are so seriously below those commanded by the average individual or family that they are, in effect, excluded from ordinary living patterns, customs and activities."[269] p.32.

Hereafter, the term 'poverty' is used in place of 'relative poverty', albeit on the understanding that affluent world poverty is mostly far less serious than the absolute poverty of the developing world.

In terms of understanding the causes of social exclusion, the definition used in this thesis draws from the 'strong' interpretations, in which social exclusion is viewed as an "active process driven by powerful actors and mechanisms in the three spheres of the market, the state and civil society." (Gore et al 1995 in[270])p.784. This definition contrasts with the 'weak' conceptualisations which are mainly descriptive and less specific about causal agents.[258] There is also recognition in the definition used here, following Byrne's neo-Marxist analysis, that the exclusionary process has clear collective benefits for employers and
4. Social exclusion: a framework for understanding health disadvantage

owners of capital.[246] The processes which cause social exclusion are discussed in greater length below, but first it is useful to discuss the theoretical underpinnings of a 'strong' interpretation to explain the deeper rationales behind the exclusionary processes involved.

4.3 The dimensions of social exclusion

Although many researchers emphasise the multi-dimensional nature of social exclusion [39, 246, 250, 257, 262] and a narrow focus on economic factors has been criticised,[268, 271] there is widespread recognition that the economic dimension should be given causal primacy in understanding the problem, specifically unemployment and/or poverty.[39, 246, 251, 271] Where there does appear to be an issue is with the singular focus on unemployment as the cause of social exclusion and employment as its solution. This view is fairly dominant in European policy approaches, where "exclusion from the labour force has tended to be viewed as the key indicator of social exclusion"[257]p.11, and social exclusion remedies have often focused on measures, sometimes quite vigorous, to reintegrate people into the job market.[268, 272, 273] The following discussion highlights the limitations of this view and the position is put that it is more useful to understand social exclusion as being founded on poverty. This understanding does not deny the importance of employment, for, clearly, poverty is often a consequence of unemployment, but it is necessary to recognise that there are other pathways to a deficient income. Furthermore, employment per se does not guarantee social inclusion.

4.3.1 Poverty

There is a great deal of confusion around the issue of poverty in the social exclusion literature: is it a cause, an effect, or a feature/dimension of social
exclusion? Poverty and social exclusion are often used synonymously or as twin terms, as in 'poverty and social exclusion'. Despite the uncertainty, there is wide agreement that poverty does not directly equate with social exclusion, hence the necessity of a new term; the shifting discourse has reflected "a redirection of the emphasis on material deprivation of the poor towards their inability to fully exercise their social, economic and political rights as citizens." (Leibfried 1993 in [270]) p.78. However, with some possible exceptions (e.g. detained or remote populations, and societies containing severe racism or sexism), poverty is overwhelmingly the basis of exclusion in affluent countries and social exclusion cannot be discussed meaningfully without reference to poverty.

Extremely poor people can and sometimes do live lives marked with high degrees of social inclusion; however, in the market dominated economies of advanced industrial nations, much of a person's participation, life opportunities and even aspects of identity are dependent on their purchasing power. Townsend developed a conception of poverty that related to people's ability to participate in normal life, rather than whether they had sufficient resources on which to subsist. This understanding of poverty is contested, with some commentators preferring a definition relating to the ability to afford basic necessities. However, there is strong support for the Townsend view and this perspective is also consistent with a view of social exclusion in which the focus is on full social and economic participation rather than just the ability to meet basic food and housing requirements.

In countries in which poverty is relative rather than absolute, incomes below a particular level appear to result in a sharp drop in people's capacity to obtain 'socially perceived necessities'; extra requirements must either be forgone
or bought at the expense of essentials. This problem is in evidence in Britain, where people were surveyed as to which goods they perceived as necessities and whether they could afford them or not. The survey found that significant percentages of respondents could not replace or repair appliances, maintain their houses or holiday once a year, even though most people regarded these services as 'necessary'.[263]

Perhaps even more critical than the inability to purchase some goods is the way in which a lack of income acts as a barrier to choices about housing, location, services and participation in activities that most people in a society take for granted. Although these types of restrictions are unlikely to be life threatening, lack of income can impact on people in a multitude of ways. Poor people have a limited range of places in which they can live, restricted to areas in which public housing is built or to the less desirable suburbs. There is usually very little choice about schooling, and poor families face difficulties with obtaining extra assistance for children with special or educational needs.[278] In countries without free or low cost dental services, poor people often face difficulties in accessing dental care[277, 278] and may experience bad oral health.[279, 280] There are also the day to day challenges which make the lives of low income people qualitatively different to those of the rest of the population; for instance, not being able to afford school excursions or trips to recreational facilities or films.[277, 278] These difficulties can compound one another; in Australia, for example, people who are less able to afford a car are more likely to live in suburbs with inadequate public transport (see Chapter 6).

There is also a sense of precarious living brought about by poverty; for instance in the UK survey (above) 25% of respondents stated that they were unable to save small amounts of cash. People have usually used up all their savings by the
time they are living in poverty. They also have lower levels of asset and home ownership to buffer them against future financial difficulties.[277] Thus, unexpected large bills or medical expenses are likely to cause substantial difficulties for low income households.

4.3.2 Does unemployment equate with social exclusion?

If poverty was primarily a result of lack of work it would seem reasonable to identify social exclusion as an employment issue and focus efforts in this area; however, this perspective misses two important points. First, there are large numbers of poor people for whom employment is not currently (or may never be) possible;[268, 281] for instance, those engaged in unpaid work, such as parents of young children (sole, or partnered to an unemployed or low paid worker) and carers of aged or disabled relatives, and also those not in the workforce, such as elderly, disabled and sick people.

Second, although employment can be the way out of poverty, making possible a wider range of consumption and participation opportunities, it only does so if it provides a sufficient income and is reasonably secure. That employment will end poverty can in no way be assumed, particularly in countries without set minimum wage levels or welfare subsidies for low income earners. Those in 'poor' or precarious work (extremely low paid and/or casual and insecure) are often little better off than the jobless.[282] This fact is apparent from large numbers of working poor throughout the world, including those in many affluent countries. The United States is an extreme example of high numbers of working poor, where over 1 in 6 non elderly Americans live in a working poor household.[283] Also, in Australia, where for many years fulltime employment

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7 The working poor are those “families whose earnings are less than twice the federal poverty level and in which the adults work an average of half time or more during the year.” [As defined by the National
was a guarantee of a reasonable standard of living, there has been continuing growth in the numbers of working poor,[285] with a recent estimate that "over 1 million Australians are living in poverty despite living in a household where one or more adults are in employment."[264]p.xviii.

These issues considered, unemployment still needs to be recognised as one of the main routes to poverty.[264, 286] Unemployment benefits are usually set below the minimum wage in a nation or, in nations offering unemployment insurance, payments are only for limited periods of time.[287] This strategy means that a prolonged period of unemployment makes poverty highly likely after savings are eroded and assets sold off. Furthermore, long periods of unemployment make re-employment more difficult, as people lose skills[288] and their connections with others in the workplace and job referral networks.[289] A long period of reduced income also severely limits the social activities in which the unemployed can participate. In this sense, unemployment is a double and compounding exclusion, creating both poverty and reduced social participation.

At a locational level, growing numbers of unemployed and the geographic concentrations of joblessness contribute to the growth of socially excluded populations and locations; for instance, the effect of the change in employment is most clearly evident in industrial cities and regions in which large employers have laid off large numbers of workers[290, 291]. These de-industrialised 'rust belt' areas can decline very rapidly, with the loss of local spending power spinning off into further business failure, unemployment and loss of services. Examples include: Philadelphia and Detroit in the US[291], Newcastle and

4. Social exclusion: a framework for understanding health disadvantage

Liverpool in the UK and, in Australia, the towns of Elizabeth (SA), Broadmeadow (Vic) and (more recently) Newcastle and Wollongong (NSW).[292, 293]

4.3.3 Do other social circumstances of social exclusion need to be considered?

It is evident that poverty, regardless of its cause can limit people's chances for full participation in society. This is most clearly the case in relation to the forms of social participation which require money, such as consumption of most goods and services and many social and sporting activities. As such, it is important to consider other social situations which lead to poverty and then social exclusion. These include sole parenthood, old age (without home ownership), disability, sickness, or being part of a group which is racially/ethnically discriminated against.[264, 277, 294]

However, these social situations do not by necessity make a person poor. Poverty may not result in instances where costs of living are comparatively low; for instance, people may have low incomes but be financially secure by virtue of owning their own homes.[294] Alternatively, levels of income support (including in kind services) can influence whether or not people live in poverty; for example, sole parenthood is far more likely to result in poverty in the US than in Sweden.[295] Thus, it is not simply a matter of pointing to states such as sole parenthood or unemployment and equating them with social exclusion; there is a need to look deeper into the causes, to see why and to whom poverty is permitted to happen. This issue is discussed in the next section.

There are many other possible facets to social exclusion and the term has been defined with reference to a range of issues such as early school leaving, poor
4. Social exclusion: a framework for understanding health disadvantage

Health, increased mortality, homelessness, social disintegration and bad housing.[296] The difficulty with adding numerous defining issues is that it risks making social exclusion a catch-all concept into which any social problem can be included. This conflation obscures those problems that are an effect of social exclusion rather than being a cause; it can also create confusion when relatively minor problems are given the same weight as more major ones;[268] for instance, the Blair Government has been criticised for a heavy emphasis on teen pregnancy.[297]

It could be argued that a factor might be both cause and effect of social exclusion (e.g. early school leaving could be both). For reasons of conceptual clarity, it is most useful to give primacy to the core dimension of poverty and the main pathways to poverty, rather than the more diffuse consequences of social exclusion. Health is a particularly good example of the need to be clear about what is involved in social exclusion; being socially excluded increases a person’s chances of dying earlier and getting sick; however, poor health in itself does not mean a person is socially excluded. This is not to say that secondary issues can not compound exclusion, but rather to take the position that it is more useful to consider these issues as problems from which social excluded populations are at an increased risk of suffering; that is, they are not defining issues.

4.3.4 The deeper causes of social exclusion.

Poverty has been regarded as a natural condition, "governed by scientific laws of population and resources."[272]p.3. This argument would seem to be unsustainable in affluent nations, where proportions of the population have vast wealth and in which governments control multi-billion dollar budgets. In any society affluent members can make choices about whether or not to protect the
more vulnerable members and what quantity of resources will be redistributed from the more productive to the less productive;[272] for instance, in a tribal society children and the elderly were usually supported by the other members of the group, but the weaker members may have been abandoned in times of hardship. In complex capitalist societies it is more difficult to see how some people come to be excluded and others included.

From conservative and neo-liberal perspectives, the blame for social exclusion can be laid, at least partially, with excluded individuals; taking the view that the overgenerous and easy provision of welfare has encouraged the growth of unemployment, family breakdown and single parenthood, along with a spectrum of social ills.[298, 299] Australian right wing commentators have been more restrained, but there is still often an element of 'victim blaming' in their rhetoric; for instance, Australia's former Minister for Industrial Relations, Tony Abbott, notoriously accused the unemployed of being 'job snobs' and argued that the problem "can also boil down to questions of personal choice as well as that of governments."

Despite such attitudes, the evidence is that social exclusion is more closely related to structural economic change and growing income polarisation rather than individual failings. Over the past two decades structural unemployment resulting from a decline of manufacturing and heavy industries has become a significant problem in affluent nations.[301] During the 1980s and 1990s demand for workers dramatically diminished in these industries as a result of improved technology and the relocation of businesses offshore to countries with cheaper labour.[286] This shift in the labour market has meant that previously secure manual manufacturing jobs, largely held by men, have greatly diminished, leaving many reliant on casual work and welfare payments;
Australia experienced massive job decline in this sector, with the loss of over one quarter of a million manufacturing jobs.[302] A subsequent rise in service sector employment has not assisted in providing jobs for the displaced workers as, by and large, these workers have lacked the skills and experience to undertake this employment.[302] In any case, service sector jobs are low paid, part-time and predominantly occupied by female employees.[247, 303] In addition, many of the displaced do not register as officially unemployed, as a person need only work one hour a week to be excluded from official unemployment statistics.[304]

Accompanying the loss of manufacturing employment and the rise of part-time and 'junk jobs' in affluent nations was a significant increase in income polarisation, [31, 241, 305] a trend that has continued to the present day. In general, this has meant a small proportion of people have grown much wealthier, a larger number of people have become relatively poorer and the number of people on middle incomes has declined.[243] Given that poverty is often defined relative to incomes in a nation (for instance, 40 percent of median income), a growth in income disparity can also mean increasing numbers of people living in poverty. This might have less impact if everyone's incomes were increasing, but the poor have also seen a decline in income in absolute terms in many affluent nations;[31, 306] or, as in Australia during the 1990s, all incomes increased but the lowest quintiles increased by only 1.5% compared to 14% for the upper quintile.[243](pp.5-6).

4.3.5 How does social exclusion happen?

Given the transformation in global economies over recent decades, it would be possible to take the view that governments are at the mercy of the forces of
globalisation and unable to affect the resulting economic upheaval or impact on their populations. Although such a view might be preferable to victim blaming philosophies, it belies the true power of governments in affluent nations to play a moderating role in either exacerbating or reducing the impact of globalisation.[302] There are a number of policy levers through which governments can directly and indirectly influence income distribution and the levels of incomes at the bottom, through the levels of provision of welfare and through tax transfers, for example. Governments are also able to intervene in labour markets by increasing or reducing the levels of regulation in this sphere.

During the 1980s and 1990s the economic crisis and growth of unemployment and loss of manufacturing jobs resulted in different policy responses across nations. It is widely held that nations with well developed welfare states were better able to shield sections of their populations from deprivation and isolation in these years.[241, 266, 267, 307-309] Hertzman notes that during this time, although market income inequality increased in all affluent countries, "in several, income inequality post-tax and transfer did not go up at all, or not as much as market income inequality."[309]p.2007 These nations were those with more equitable income and in which redistributive demands were met by tax transfers and welfare state programs. However, different responses to economic crisis did not vary just in the sense that some nations provided welfare support to displaced workers whilst others did not; the response of some nations was characterised by severe cutbacks in welfare and in the protection provided to workers. It was these nations, namely the US, the UK and New Zealand, who exhibited the greatest increase in income inequality.[305]

There is evidence to demonstrate that interventionist government policies to deregulate labour markets have made a significant contribution to increasing
wealth gaps.[306, 310] These policies were instigated as a response to the global economic crisis, to make workforces more efficient and flexible with the aim of improving productivity and competitiveness. They include a combination of the following elements:

- increased wage flexibility (especially downward)
- relaxation of minimum wage policies
- easier hiring and firing
- decentralisation of wage bargaining (e.g. work place bargaining)
- reduced trade union power, and
- reduction in levels and length of payment of unemployment benefits (plus general tightening up of eligibility).[305, 311]

Overall, such measures have resulted in minor productivity gains and large increases in job insecurity and the erosion of wages and conditions for lower paid workers.[312]

These policy decisions cannot be understood separately from the ideologies which drove them. The ideological and political commitment to increased labour force flexibility, reduced union power and reductions in the provision of the welfare state are core elements of neo-liberal philosophy[241, 301, 310, 311] (or 'economic rationalism' as it is termed in Australia[313]). Thus it was not just a matter of governments choosing different ways of responding to economic crisis; the policy choices they made were driven by a political philosophy. According to neo-liberal thinking, people should be responsible for themselves rather than being dependent on the state, a philosophy which emphasises social
responsibility over social rights. Therefore, it would be expected that in
difficult economic times governments who adhere to this philosophy would be
less likely to assist the disadvantaged.

Although a declining role for the state is a central tenet in neo-liberalism [301,
310, 314] it has been argued that neo-liberal governments did not actually
reduce their activity, just changed its focus, shifting direction from social and
redistributive actions to becoming an instrument of private business
purpose. [307] Indeed, the embracing of neo-liberal philosophies has been has
been marked by extensive government intervention; for instance, the
deregulation of labour markets in Australia and the UK has seen high levels of
government activity, including the union busting of the Thatcher years in the
UK and legislative shifts in Australia which have enforced enterprise bargaining
in favour of centralised wage fixing. [315]

4.3.6 Social exclusion and stratification

From the discussion so far it is apparent that a proportion of the population is
being cut-off from full social and economic participation. Some sectors of the
population are clearly more vulnerable to exclusionary processes than others;
that is, the risk of becoming socially excluded is not equal through the
population. This section discusses the intersection of social exclusion with other
forms of social stratification, namely class, gender, race and ethnicity.

4.3.6.1 Social class

In many quarters 'social exclusion' has superseded class descriptors to refer to
the people at the bottom of the social hierarchy. However, there are still a
number of pertinent questions relating to the relationship between social class
and social exclusion. Is social exclusion just a replacement term for the
4. Social exclusion: a framework for understanding health disadvantage

‘underclass’? Are the socially excluded a class in themselves? Can social exclusion be understood as part of a class schema? And, what is the relationship of social exclusion to the working class?

During the 1980s and 1990s a number of analysts from both the left and right of the political spectrum identified an 'underclass' as a distinct social group 'beneath' the working class.[298, 299, 316, 317] Right wing commentators described this group as culturally separate in a 'morally corrupt' fashion; for example, Murray argued that the underclass, by virtue of choosing to behave aberrantly (e.g. having children outside marriage, welfare dependency, participating in crime and violence), differ from other low income earners.[298, 299] This analysis has been largely discredited in academic circles, for ignoring the effects of structural unemployment and institutionalised racism[317] and for failing to recognise that most women become sole parents as a result of marriage breakdown, rather than as a 'lifestyle choice'.[318]

Underclass sociologists, whilst less damning, also understand that there is a distinct group:

...a social group or class of people located at the bottom of the class structure who, over time, have become structurally separate and culturally distinct from the regularly employed working class and society who are now persistently reliant on state benefits and almost permanently confined to living in poorer conditions and neighbourhoods.[319]p.4.

This definition overlaps with that of social exclusion; however, there are key differences. It is not clear that there is a culturally separate group (either in a deviant or other behavioural sense); for example, people living in poverty have been shown to share similar aspirations to the more affluent members of
4. Social exclusion: a framework for understanding health disadvantage

society.[319] Wilson argues that a culture of poverty is not the problem; rather, the isolation of poorer people from wider society has led to isolation and separation from job networks,[317] factors which in the US are exacerbated by institutionalised racism.[320] Drawing a line at 'regular employment' is also questionable, given increasing numbers of working poor (see above). Additionally, with increasing labour force flexibility, many people are forced to take casual and part-time work even though they would prefer to work full time.[321]

Thus, in terms of their relationship to the labour market, the socially excluded cannot be understood as a structurally separate class. Some may have full time work, others may work part-time or casually (as do large numbers of the general population) or be currently unemployed – the difference between these people and the non-socially excluded population is that they earn less and/or they lack an earning partner. Even those groups who appear to be outside the labour force (e.g. single parents) form a group of potential workers and can rapidly become regular workers in response to limitations on welfare.[246] This issue is evident in the United States: after many individual US states moved to time limited welfare benefits, the proportion of single mothers in employment increased from 60% to 72%.[322]

Byrne argues that post-industrial societies have become stratified along three tiers headed by a "super, and super exploitative rich with a 'squeezed middle' of relatively but not absolutely secure workers, and a large and emiserated poor."[246](p64) In contrast to the conception of a separate underclass, Byrne's model recognises that there is a relationship between middle and bottom: the socially excluded may be worst off but there are many others at risk, with continuous movement between the bottom and middle layers. Empirical
4. Social exclusion: a framework for understanding health disadvantage

evidence for this phenomenon is apparent in the disappearing middle or 'donut effect’ on incomes[323] and increasing job insecurity for middle class people.[324]

The socially excluded can be understood as a vulnerable and growing part of the working class.[246] They are working class in the Marxist sense of only having their labour power to sell. In addition, they face the burdens of being unable to obtain secure or well paying jobs, due either to low skill levels, high unemployment in their location or family responsibilities. More affluent workers are not necessarily protected from moving into a similar situation as real wages fall, and those in previously secure work can easily find themselves insecure through retrenchments, marriage breakdown, illness, disability or old age.

Byrne also sees that the socially excluded function as a 'reserve army of labour'; using this Marxist term to describe the corrosive effect on wages and working conditions of the existence of a large pool of people who are unemployed, under-employed and insecurely employed.[246] Having this group 'waiting in the wings' means that people at the bottom end of the employment market in low and unskilled occupations are easily replaceable. In the absence of government protection for low paid workers and with a low level of minimum wages, the ability of the lowly paid to demand higher wages and more secure working conditions is seriously compromised.

4.3.6.2 Gender

In many countries one of the most certain routes to social exclusion is becoming a sole parent. In the wake of relationship breakdown, women most often end up with the primary care of any children. In Australia, ninety percent of sole
parents are women[325] and about 23% of them live in poverty;[277, 326] even relatively affluent women can expect a dramatic decline in resources on separation.[327] This strongly gendered aspect of the creation of social exclusion is reinforced by the insecure attachment to the labour force of many women. Extended spells out of the workforce due to childrearing and a concentration in part-time and casual jobs, combined with the segregation of women into gendered low paid work mean that, as a group, the earning capacity of women is far less than that of men.[295]

In this sense, women in general, not just sole parents, would appear to be more susceptible to poverty. This tendency is illustrated in a study involving eight affluent nations, the United States, Australia, Canada, France, West Germany, the Netherlands, Sweden, and the United Kingdom, using data from around the mid-nineties; with the exception of Sweden, female rates of poverty were higher in all nations.[295]

Gender disadvantage can work the other way as well; in Australia, for example, since the above study was undertaken, male poverty rates have caught up with those of females; according to the National Centre for Social and Economic Modelling (NATSEM), poverty figures for males and females are both around 11%.[264, 328] The authors attribute the increase in Australian male poverty to rises in male unemployment compared to female unemployment over the last decade, due to factors such as losses in male manufacturing employment and the growth of female dominated service industry employment.[329]

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8 There is wide disagreement amongst poverty researchers on the ideal way to measure poverty. NATSEM uses income poverty rather than expenditure poverty.
4. Social exclusion: a framework for understanding health disadvantage

4.3.6.3 Race and ethnicity

Race and ethnicity tend to be more variable determinants of exclusion than are class or gender. This is because the influence of race and ethnicity on poverty can vary according to the histories and manifestations of intolerance in a particular nation. Discrimination on the basis of ethnicity and race can exclude people from employment, housing and full social participation due to factors such as not having legal status as full citizens and racism by employers, landlords and others.[330, 331]

Amongst affluent nations, the US provides a stark illustration of the links between social exclusion and race; for instance, blacks have almost three times the poverty rate of whites[332] and experience much higher rates of segregation into ghettos.[333] In Australia, race is also a powerful determinant of exclusion, albeit that a much smaller population is affected. Indigenous Australians suffer poverty and unemployment rates far in excess of the rest of the population.[334]

As an indicator of this disparity it has been suggested that absolute rather than relative poverty measures would be more appropriate for many indigenous communities.[277]

Migrating to a new nation also creates a risk of social exclusion, particularly if migrants do not speak the native language; for instance, in Australia, non English speaking migrants have substantially higher rates of poverty than English speaking migrants and the Australian born population.[329] Immigrants have also tended to be adversely affected by increasingly competitive labour markets; in the past work has acted as a mechanism for the inclusion of new migrants, but with the massive decline in numbers of the jobs which they traditionally held, integration has been made increasingly difficult.[39] And for
those migrants deemed illegal, harsh and punitive policy responses have ensured the most severe forms of exclusion.[331]

4.4 Excluded spaces: the relationship between location and exclusion

Being poor and without a secure well paid job explains the exclusion of individuals and households, but exclusion also takes place at a locational level. Cities are not uniform: within each exists "a socio-spatial geometry of difference and segregation."[39]p.83. There are often, for instance, obvious physical differences between locations: desirable wealthy suburbs with spacious housing, attractive streetscapes and well maintained amenities, contrast with poorer suburbs with more modest or slum housing, derelict shops, proximity to heavy industry, traffic arteries and other undesirable features. However, rich and poor people are not divided neatly by location, the degree of income segregation varies markedly between different countries, and within different cities.[307]

Having said this, there is a clear trend towards greater locational segregation by income in a number of OECD countries.[306] This phenomenon occurs for a number of interacting reasons, including those specific to the history, geography and social and housing policies of particular cities. As has been discussed above, income inequality has increased as a result of rising unemployment, labour market deregulation and the increasing numbers of sole parents and aged people in most industrialised nations. In the absence of a regulated housing market, segregation can become a physical manifestation of income inequality. Even if incomes are increasing for all groups, competition for housing can still result in locational inequality. "Neighbourhoods offering a more desirable set of locationally fixed amenities will become more exclusively occupied by richer
4. Social exclusion: a framework for understanding health disadvantage

households”[306]p.20, with poorer households outbid and so forced to relocate less appealing suburbs.

Beer and Forster, in their analysis of the causes of locational segregation by income in Australian cities, point to a number of causes for the creation of poor suburbs.[302] Historically, there has been a tendency for workers employed in manufacturing industries to be located together, often in purpose built public housing, meaning that the decline of this sector created disproportionate levels of unemployment in these working class locations. The subsequent change in targeting of public housing to welfare dependent households rather than the low wage employed has further increased the proportion of workless families in these locations, to the extent that a very small proportion of residents of public housing are employed at all[335, 336] (for more detail see Chapter 6). Similarly, in the US: "some of the most income-segregated neighbourhoods are the site of public housing, where residents' eligibility depends on their income.”[337]p.14.

Another factor which may compound the spatial concentration of disadvantage is the association between unemployment and family breakdown. Webster shows that there is a strong correlation between male unemployment and numbers of sole mothers in the industrialised regions of the UK, and notes that chances of relationship breakdown increase by 70% with the loss of male employment.[338] The geographic concentrations of job losses in manufacturing and other blue collar areas of employment are accordingly potentially translated into much larger numbers of households at risk of poverty, as families fall apart under the strain. A similar correlation between high unemployment and sole motherhood has been observed in Australia by Birrell and Rapson.[325] However, Birrell and Rapson suggest that the reason for this association is a result of the lack of employment prospects for both young men and women in
4. Social exclusion: a framework for understanding health disadvantage

these locations; thus sole parenthood occurs as reasonable choice compared to unemployment or partnership with an unemployed male. This study is discussed further in Chapter 6.

Some researchers have also noted the tendency for disadvantaged locations to become stigmatised;[246, 281, 302] the identity of 'bad suburbs' becomes part of the common knowledge of residents in any city. This knowledge can create discrimination when seeking employment,[246] leading some residents to lie about where they live when completing job applications.[281] It also emerged in the case study in this research (see Chapter 8) that residents in disadvantaged areas are often well aware that they are the focus of numerous helping efforts and 'special projects' – it might be expected that this gives residents' the impression of being considered a deficit population.

There is, however, good reason to be cautious about over emphasising the degree of residential segregation by income – in general, many more poor people live outside disadvantaged locations than within them; for instance, although segregation appears quite marked in areas in the US, only 15% of the poor population live in areas of concentrated poverty.[339] There is also considerable variation between countries with segregation in many European cities far less than that of the US[305]: Musterd argues that "Western countries should not be treated as if they are all the same.[307]p.5. Segregation can also change over time; for example, there has been a large decline in economic segregation in US cities in recent years: between 1970 and 1990 the population of poor locations (where the number of people living in poverty exceeds 40%) doubled, but between 1990 and 2000 this population fell by 25%.[84] This change has been attributed to rising incomes amongst poor populations and the
influx of wealthier people into poor locations.[84] Income segregation has not been extensively studied in Australia – this issue is returned to in Chapter 6.

4.5 Conclusions

The purpose of this chapter has been to define social exclusion and to illustrate the challenges that might be involved in attempting to address social exclusion in order to reduce health disadvantage. This process involved discussing:

- the core dimensions of social exclusion
- the processes which create social exclusion
- how social exclusion intersects with existing social stratifications, and
- how social exclusion relates to location.

Social exclusion is a particularly useful concept to apply to understanding health disadvantage and to use in determining the issues that may need to be addressed in order to reduce health disadvantage. Descriptively, the concept covers the groups who experience particular health disadvantage; most specifically the poor, the unemployed and sole parents. At a causal level it includes the processes which create and marginalise disadvantaged groups from full social and economic participation. Conceptually, social exclusion is compatible with both psychosocial and neo-materialist views on the causes of health disadvantage. That is, it encompasses both relative deprivation (people are excluded in relation to others in the society in which they live) and also contains explicit references to the processes and real material differences which underlie the deprivation in relation to others: namely unemployment, lack of
affordable housing and deliberate policy decisions by governments which favour business enterprises over the disadvantaged.

Social exclusion is also conceptually compatible with a life course model of the development of health disadvantage (the idea that poorer health outcomes are a consequence of accumulating exposures from preconception through to old age – see Chapter 2). This conceptual compatibility is based on the fact that social exclusion is not a 'fixed state' but one which people might move into and out of, just as in the life course model people may be alternatively exposed and less exposed to health damaging factors in different periods of their life. It is also possible to bring the two concepts together – in the sense that the more time a person spends socially excluded in their life course, the worse health outcomes they can expect. Another conceptual parallel between the life course model and social exclusion is the idea that negative exposure at one point in their life can make a person less resilient and more likely to suffer disadvantage at another point – thus, in the same way early childhood health disadvantage makes later health disadvantage more likely, so too does early social exclusion; for example, leaving school early increases a person’s chances of unemployment, and low income workers are more susceptible to unemployment.

The key strength of using social exclusion as a framework to understand health disadvantage is the explicit recognition of exclusionary process. People are not just low income earners or low social class, they are excluded due to a clearly recognisable set of processes.
These processes (in affluent nations) include:

- the decline in manufacturing industries
- increased labour force flexibility
- reductions in the provision of the welfare state
- increasing income polarization
- housing policies and markets, and
- the ascendancy of neo-liberalist philosophy and policies.

Furthermore, vulnerability to exclusionary processes is not spread evenly across the population but is centred amongst those who are most likely to suffer from poverty, unemployment and insecure employment: the working class (particularly male blue collar workers), single parents, the elderly, new migrants and those suffering discrimination on the basis of race or ethnicity.

It is also important to recognise that the extent and depth of social exclusion in a nation is a function of the choices made by the government of that nation; for example, whether the unemployed and socio-economically disadvantaged should be protected and given income support, or whether they are left (or forced) to make their own way; and whether minimum wage levels will be set above or below the poverty mark.

Exclusionary processes also have a locational dimension, and there is clearly a tendency for people to be channelled into certain locations on the basis of their income. However, there is a danger in thinking in terms of exclusionary places rather than excluded people. If exclusion becomes something directly associated
with location – for example, the ghetto or the areas of concentrated public housing – there is a distinct possibility that the processes that cause people to end up in particular locations might be overlooked: that is, income segregation needs to be understood as a variable end product of exclusionary processes. These issues are discussed in relation to income segregation in Australia in Chapter 6.

Overall, given the aims of understanding and reducing health disadvantage, using a framework of social exclusion gives a wide overview of both who is socially excluded and hence socio-economically disadvantaged, and also why they are socially excluded. In short, it informs us as to which issues 'need to be dealt with' in order to reduce social exclusion, socio-economic disadvantage, and so health disadvantage. The problem, of course, is that many of these issues seem far from the influence of those interested in health equity. However, whilst delineating the magnitude of the problem can highlight what is not possible, it also potentially reveals what is possible and where efforts might be most productively focused. The stated aim of this research is to determine whether a locational approach to challenging health disadvantage is one potential way forward to address health disadvantage; in the next chapter the discussion examines the relationship between health disadvantage and location more closely.
5. Does location matter? The relationship between location and health

5.1 Introduction

Death and disease are not evenly distributed across locations, a phenomenon starkly revealed by maps of geographical variations in health.[4, 27] The regions and suburbs with lower than average incomes are marked by higher rates of disease and earlier age of death, reflecting the negative relationship between income and health. This phenomenon of locational patterning of health outcomes is described in the health and location literature as a 'compositional effect'. It has also been argued that residence in a disadvantaged location can have an additional, or 'contextual effect' on peoples' health due to, for instance, living in a run down and dysfunctional neighbourhood. The apparent relationships between location and health are often presented (or implied) as reasons for intervening locationally to address health disadvantage.[340, 341] This chapter considers the validity of this rationale by exploring the relationship between location and health disadvantage and the ways in which this relationship has been conceptualised in the literature.

The study of the effects of location on health has emerged as a distinct and growing stream within the health inequalities literature. Although the study of locational variations in health has a long history in public health, from around the 1990s there has been a substantial growth of research in this area. Increased interest appears to be part of the wider surge in health inequalities research generally and associated investigations into the socio-economic determinants of health.[24] In addition, new research approaches have been enabled through the development of multilevel statistical methods.[24] These allow the separation of
5. Does location matter? The relationship between location and health

compositional and contextual effects at the locational level so that the independent impact of location on health can be studied.

This chapter is organised around a critical discussion of these two central concepts – composition and context – as used in the location and health inequalities literature. Within this framework, the questions below are considered.

- To what extent can a clear relationship between location and health be observed?
- What are the causal mechanisms that have been hypothesised?
- Are the hypothesised causal mechanisms a reflection of verifiable observations?
- Are the findings about location and health generalisable across nations and cities?
- Does the research indicate a sufficient strength of relationships between location and health to justify intervening at a locational level?

Drawing from the discussion of these issues, the implications for locational interventions to address health disadvantage are considered. This chapter also provides the foundation for the next chapter, which discusses the locational dimensions of the socio-economic determinants of health (e.g. unemployment and sole parenthood).
5. Does location matter? The relationship between location and health

5.2 Composition

The term 'compositional effect' refers to differences in health outcomes between locations which reflect differences in the aggregated individual characteristics of each population. To illustrate: the compositional effect relating to lung cancer of a particular location would be obtained by aggregating the numbers of local people with that disease then converting those numbers to a standardised rate. A higher rate of lung cancer in one location when compared to another would thus purely reflect differences in composition. As such it is not, strictly speaking, an 'effect' but an observation; the location itself is not seen to influence incidence rates of disease or death. Locational differences in health due to composition are well documented in Australia and elsewhere.[4, 27] This effect is to be expected given the congruence of tendencies for socio-economically disadvantaged people to have worse health and to live near one another in less expensive parts of a city. The measure of compositional effect is used extensively in Australia to document health inequalities where location is used as a proxy for socio-economic disadvantage (e.g. [3, 4]).

One of the main ways compositional effects on health have been measured in Australia is through applying the Socio-economic Indexes for Areas (SEIFA) Index of Relative Socio-economic Disadvantage (IRSD) to different locations and comparing the health outcomes of these locations.[4, 342] The IRSD combines factors such as income, unemployment, numbers of indigenous people and people from non-English speaking backgrounds to create a composite measure of disadvantage.[343] This figure then enables locations to be ranked from most disadvantaged to least disadvantaged. It has been used in Australia for the four-yearly National Health Survey,[87] and in the Social Health Atlas[4](the most comprehensive mapping exercise of spatial differences in health in Australia).
Compositional effects give a very tangible indication of health disadvantage; for example, Figure 4 shows that people living in the poorer suburbs to the west and south of Sydney have considerably higher death rates from cardiovascular diseases.\footnote{These figures have been standardised by age so do not reflect a skewed distribution of older people.}

**Figure 4.** Cardiovascular deaths by SLA, Sydney, NSW. (reproduced from Glover and Tennant, 1999 [344])

However, even though maps such as this are frequently used to measure health inequalities, they certainly do not give the complete picture. One of the key problems with using aggregated data from locations containing a range of suburbs and neighbourhoods is that it can mask the true extent of disadvantage and poor health experienced within that location. Vos and colleagues note, for
5. Does location matter? The relationship between location and health

instance, that The Port Phillip LGA (local government area) in Victoria contains very wealthy, 'upcoming' and disadvantaged areas and, while the LGA has worse than average health outcomes, it would be expected that the differences between locations would have been even greater if analysed at suburb level.[345] They also speculate that the difference in male life expectancy of 7 years between most advantaged and most disadvantaged LGAs would be larger had a smaller level of analysis been used.[345]

This inaccuracy of locational level data is a common frustration amongst authors, as they are often not able to adequately analyse the permutations of health and socio-economic disadvantage of smaller locations.[346, 347] It occurs primarily because of a lack of data at the desired level; for instance, although it is possible to get very precise socio-economic data down to the level of collector district (around 200 households) in Australia, there is little corresponding health data for areas smaller than Statistical Local Area (SLA – roughly equivalent to LGA). Researchers are able to get mortality data down to postcode level from the ABS, although this is considered fairly unreliable.[348] At this point the only Australian data set measuring health outcomes at collector district level is the HILDA (Household, Income and Labour Dynamics) longitudinal study that includes 488 collector districts out of a total of around 70,000.[349] There is a perceived need amongst Australian health inequalities researchers for studies to more accurately measure differences in health at a smaller locational level.[348]

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10 Precise to the extent that the Australian census is an accurate reflection of individual and household social and economic characteristics.
5. Does location matter? The relationship between location and health

5.2.1 The usefulness of compositional effects

In theory, the mapping of compositional effects and the clear revelation of a 'health divide' could potentially be used to assist in addressing health disadvantage. Any degree of concentration of health disadvantage does suggest that there will be a higher need for health and other services in that location. This information might also be used as an impetus to address the socio-economic determinants of health in that location, informing, for instance, agitation for more services or economic investment in particular locations. There are, however, extensive limitations to the usefulness of observed compositional effects on health. As the above discussion has revealed, socio-economic segregation and the associated concentrations of health disadvantage are at present only crudely reflected by locational measures; that is, a selected location may contain a diversity of socio-economic groups, hiding the depth of disadvantage that exists within them.

On the other hand, given that socio-economic segregation is only ever partial, those locations which show up as health disadvantaged will not contain all those people suffering a health disadvantage. The health disadvantaged are not conveniently confined to an exclusive and limited range of suburbs, even if 'health maps' give this impression. It has been argued that focusing on disadvantaged locations (for health, social or economic reasons) will miss most of, or at least substantial portion of, the disadvantaged population in a city.[27, 350] Another point to note about composition is that it is an end result of a process not a process in itself: that is, it tells us nothing about what causes the locational patterning by income (and hence health) in the first place. There is no reason to think that just because a problem is manifested spatially, it can also be effectively addressed at that level. Also, just knowing where health
disadvantage is concentrated does not necessarily translate into effective public health action. For instance, in practice in Australia, health services are not distributed only according to need but are strongly influenced by historical and political factors and the preferences of the public health workforce (as revealed, for example, by the immense difficulties in providing adequate health care services to rural areas[351]). These issues are explored in more detail in the next chapters.

5.3 Context

Can where a person lives make them sicker and die earlier than otherwise would be expected? In contrast to a compositional effect, a 'contextual effect' refers to the features of a local environment which appear to affect health, independent of individual characteristics. It is this effect (or the search to find it) which has excited recent interest amongst researchers examining the locational dimensions of health inequalities. It would seem to make sense that living in a run down stigmatised neighbourhood with poor services and transport, located near polluting industries and where crime, violence and social problems are rife could cause additional problems for health.

Consequently, the discovery and explanation of neighbourhood effects on health is potentially of interest to health inequalities researchers, being another factor which could be added into explanatory models of health disadvantage (or advantage) of different income groups. It could also provide a means of identifying potential intervention points in communities to benefit the health of local residents. Unravelling 'context' is, however, immensely complex: the study of locational context and health is possibly the foremost example of the
methodological difficulties which beset the field of health inequalities (i.e. muddied causal pathways and sweeping conclusions based on modest effects.)

The issue of locational effects on health was largely ignored until the 1990s, but investigation into contextual effects on health has been the subject of numerous studies in recent years[352] (for reviews see [24, 346, 353, 354]). The focus of these has been almost entirely on socio-economically disadvantaged locations, predominantly from the US and the UK with, at the stage of writing, only one published Australian multilevel study examining locational effects on food access.[355]

These studies use statistical techniques which can 'separate out' individual and location level factors. Using traditional methods of multiple regression or, increasingly, multilevel software (e.g. MLwin), these analyses control for individual (compositional) factors that are known to have an effect on health, including *inter alia* individual age, gender, income and the 'big four' health risk behaviours (sedentary lifestyle, risky drinking, unhealthy diet and smoking). If these factors cannot explain the full extent of the selected outcome, the residual difference is taken to indicate the existence of a locational effect on health; for instance, it might be concluded that living in a particular location increases a person's chance of developing heart disease by 8%, independent of their individual characteristics.

In studying locational effects, the size of the study locations usually vary widely from small neighbourhoods to larger 'health areas'. Within this field of research, the terms 'neighbourhood' and 'community' are often used and "loosely...refer to a person's immediate residential environment which is hypothesised to have both material and social characteristics related to health."[24]p.1175. In reality,
5. Does location matter? The relationship between location and health

the study area is frequently predetermined by what existing data is available from data collection agencies; for example, from US census tracts or defined 'health areas'.[356]

5.3.1 Critique of contextual studies

The most forthright critique of contextual studies of location on health has come from the neo-materialist position within health inequalities research. Shaw and colleagues question the value of such studies, stating that as multilevel modelling techniques are designed to find locational effects "it is no surprise that they often do."[27]p.152. They also reiterate the finding that health inequalities are far more substantially related to individual differences in socio-economic status; although they are not opposed to reinvigorated neighbourhoods, the real solution to health inequalities, in their opinion, lies in macro level interventions to reduce overall socio-economic inequality (see Chapter 3).

While they make some interesting points, Shaw and colleagues, at first reading, perhaps do contextual studies an injustice. The critique of multilevel techniques appears unfair as the existence of a specialist tool does not in itself create particular effects and, in any case, contextual effects are not always found, suggesting credibility. Health inequalities researchers do disagree on many issues, but no-one really disagrees with the fact that compositional factors (family and individual characteristics) are more important than contextual determinants of health;[346] nor (as has been shown in Chapter 3) do they disagree with the proposition that population health would benefit from improved socio-economic equity. However, the very modest size of locational effects is a more solid concern.
5. Does location matter? The relationship between location and health

Indeed, for all the interest generated by context, the apparent independent effect of location on health is small. In a review of 25 contextual studies published up until 1998 Pickett and Pearl found a modest but consistently negative effect of neighbourhood on mortality, for which all studies observed odds ratio values of less than 2, and health behaviours, with odds ratios ranging from 1.2 to 1.7. The evidence for the impact of location on morbidity was more variable but generally modest. More recent studies (not considered in this review) have also observed modest effect sizes, mostly with odds ratios under 2.

There are a few comments to be made about these effect sizes. What these figures indicate at face value are locational effects which can result in almost a doubling of the risk of death and an increased risk of poor health behaviours of between 20% to 70%. These may sound substantial, but in epidemiological terms they may not be. Firstly, the increase is in odds ratio (or the closely related 'relative risk'), figures that are dependent on the value of the baseline risk; for instance, a small baseline risk of 10% in one population when compared to 12% in another population will gives a relative risk figure of 1.2 – a 20% increase in risk. Thus, without considering the baseline figures, the effect size may actually be quite small. Secondly, even in clinical studies, relative risks of less than 3 tend to be disregarded due to the likelihood of confounding; for instance, Taubes cites the editor of the New England Medical Journal as generally looking for a relative risk of 3 or more before accepting articles for publication. Similarly: "In epidemiologic research, [increases in risk of less than 100 percent] are considered small and are usually difficult to interpret. Such increases may be due to chance, statistical bias, or the effects of confounding factors that are sometimes not evident."
5. Does location matter? The relationship between location and health

So, in short, contextual effects on health from location are nothing to get excited about.

There is also some question as to whether such effects are generally applicable across societies and across time. Two Canadian studies failed to find a contextual effect on mortality for poor neighbourhoods.[360, 361] Effects may also disappear over a longer time frame; for instance a British longitudinal study found only very slight contextual effects for location at nine years follow up (and only for women, not men) and concluded that there was no evidence of a 'social miasma' which meant life expectancy of poor people was reduced by living near other poor people.[362] This observation remained reasonably consistent at 13 years follow up.[363] Further longitudinal studies are needed to establish whether the decline of any locational effect on health over time is a common phenomenon.

The point was made previously in this thesis that modest effect size is not in itself a reason to dismiss a particular causal explanation. It was argued that the causes of health disadvantage are so multitudinous that even a factor with a fairly modest effect size (for instance, due to differential access to health services) may be important in the overall scheme of things (see Chapter 2). However, in the instance of contextual effects on health of location there do appear to be sound reasons to be cautious. In addition to the issue of small effect sizes there are problems identifying the causal mechanisms which operate at a locational level; and, in terms of reducing health disadvantage, the practical usefulness of these studies also seems very slight.
5. Does location matter? The relationship between location and health

5.3.1.1  Mechanisms

The mechanisms offered to explain contextual effects on health vary widely between studies and are not particularly well explored;[352] many studies do not, in fact, present causal explanations for any effects they observe.[364] There is clearly a need to address this issue if the problem of context is to be better understood: that is, excess mortality and morbidity do not in themselves reveal what factors people are actually being exposed to that create a contextual effect. Additionally, general terms such as 'concentrated disadvantage' or 'high poverty area' do not reveal what factors are associated with these living environments that could adversely affect health.

It is apparent that creating an appropriate explanatory model to account for the causal mechanisms between location and health is no easy matter. The first problem is that there is no 'pre-given' set of causal mechanisms so researchers, in a sense, need to 'make them up', albeit on the basis that the factors included do plausibly affect health; for example, social capital is one possible casual mechanism that has been proposed to explain contextual effects on health.[365-367] Paralleling the studies at a state or national level (discussed in Chapter 2), it has been hypothesised that health at a neighbourhood level might be eroded by increased exposure to the stress associated with living in a poorly resourced area with low levels of trust, social support, and cohesion (or 'sense of community').[172, 368, 369]

In regard to health behaviours, researchers have suggested that 'contagion' and 'structural' factors might be associated with the increased likelihood of damaging health behaviours such as smoking or lack of physical exercise.[370, 371] A contagion model suggests that that contextual effects (e.g. higher levels
of smoking than would be otherwise expected), given individual characteristics, could be due to the 'normalising effects' of being exposed more frequently to that behaviour. This means a particular behaviour carries less stigma than it might do elsewhere by virtue of being relatively common and people may also be persuaded to take up a behaviour by their peers. A structural model refers to facets of the physical environment, such as amenities and general attractiveness. It might thus be expected that people would be more physically active in a place with bike paths and footpaths.

Macintyre and colleagues developed a model from the starting point of 'what constitutes a healthy life?'; drawing from 'Maslow's hierarchy of needs', they developed a multifactorial model which included a range of features of local communities that could feasibly affect health. Their model included factors such as the physical environment, service provision, work opportunities, socio-cultural features of the location and the reputation of the location.[352]

Although it is entirely plausible that the factors (such as have been described) do have an impact on health, there is a question of whether this theorising can provide a sound basis for intervening at locational level. The difficulty is that there may be literally countless factors which can potentially account for any contextual effect on health. For instance, a higher prevalence of smoking in a disadvantaged location may conceivably be due to any or all of the following factors: a stressful environment, peer influence, easy availability of cigarettes and lack of local 'quit programs'. Given that context only has a modest overall effect on health, determining the full range of causal mechanisms involved and the impact of each factor on health is unlikely to be either possible, nor, in all likelihood, of any great practical value (the impact of each factor being so small).
5. Does location matter? The relationship between location and health

Additionally, the development of casual mechanisms carries within it the assumption that it is actually possible to model how factors operate within a location. This issue is illustrated by a recent Australian study of neighbourhood context on social well being.[372] The authors found that, although identifying the presence and size of neighbourhood effects proved to be relatively straightforward, determining the source of these effects (causal mechanisms) was much more difficult. For instance, there was no way of telling whether people in the same neighbourhood were reacting in a similar way because of the similar environment they shared or because they were similar people; or, alternatively, whether individual behaviour was affected by the other residents in a location. These difficulties would also apply to health. To illustrate: a contextual effect on smoking could be due to the fact that either:

- most people would be influenced to smoke given residency in a particular location
- similar people who are more likely to smoke are living in the same location, or
- people are influenced to smoke because many other people smoke in that location.

Circumspection of this nature is not always apparent in the location and health literature. There is actually a high likelihood that factors hypothesised to affect health at locational level are collinear, so that something that has an apparent effect may in fact be a marker for something else. For instance, drawing from 'broken windows theory', Cohen and colleagues suggest that the level of urban decay (e.g. numbers of boarded up shops and graffiti in an location) is a predictor of poorer health outcomes because residents are less likely to walk
5. Does location matter? The relationship between location and health

around in the neighbourhood due to its unsightliness. This ignores other possible explanations and the fact that neighbourhood decay is also often associated with other health risk factors, such as high rates of crime and violence, or is itself simply a consequence of socio-economic disadvantage.

Similarly, studies that pick a collection of location level variables (e.g. concentration of poverty, number of commercial stores, number of community facilities, etc.) will perhaps find that these correlate with whatever residual contextual effect is observed, once the analysis accounts for individual characteristics. This was a notable criticism (discussed in Chapter 2) of the Kawachi and colleagues' studies linking levels of trust to health outcomes; these American study populations may have been untrusting but they also lacked basic social infrastructure. As disadvantaged locations often experience a multitude of problems, there is no certainty that the modelled factors are the actual contextual culprit: they may themselves be correlated with something the researcher failed into put in the model, for instance, levels of domestic violence.

Even if the causes of contextual effects could be determined with some confidence, they are almost certainly not generalisable. Context is also contextual and each disadvantaged location will have its own unique characteristics. This is illustrated, for example, where one study observed that residency in a disadvantaged location reduces levels of walking in the neighbourhood, whilst another study found that residency in such locations made it more likely that people would walk. Differences between disadvantaged locations are also likely to be large when international comparisons are made. It was mentioned above that two Canadian studies did not find contextual effects for health, and it seems probable that, even if these effects do exist in other societies outside the US and the UK, they are most likely
5. Does location matter? The relationship between location and health

to be caused by different mechanisms. For example, the poorest areas in Australian cities are predominantly the outer suburban areas where public housing is located; life is very different in these areas when compared to American ghettos or Scottish slum tenements, for instance.

5.3.1.2 Further problems

In addition to problems identifying causal mechanisms, there are other conceptual burdens facing contextual studies of health that further impair their utility. There does not seem to be a particularly strong reason for selecting location as the context of interest when it comes to health; for example, people are also potentially influenced by other contexts such as their work, school or family. Furthermore, people are usually not confined to a location but move in and out of it, often on a daily basis.[356] Also, people can be expected to live in a range of neighbourhoods through the life course. Compounding this issue is the fact that actual neighbourhoods are not usually used in contextual analyses (as residents might perceive them) but are often simply an artefact of other data collection processes (e.g. census collection).

Another issue raised in the literature is the differing effect of context on different people, varying, for example, by gender or class. In a Scottish study, area deprivation was related to body mass index for women but not for men.[375] Other findings have been somewhat surprising; for example, given the postulated link between deprivation and poorer health, the observation of excess mortality experienced by poor people residing in wealthy locations when compared to poor people in disadvantaged locations.[361, 376]

Accounting for these additional complexities would appear to further dilute the explanatory power of contextual models. That is, to properly understand the
5. Does location matter? The relationship between location and health

impact of contextual effects, models would need to be further modified to
account for both the duration of exposure to factors which affect health and for
the differential impact of context on different social groups.

5.3.1.3 Possibilities of contextual studies

Despite all the problems associated with understanding the effect of context on
health, the study of context may still provide some useful insights into the
creation and perpetuation of health inequalities. It could be useful in
understanding specific health exposures and specific health issues (e.g.
pollution and its ill effects). It is also possibly relevant to understanding the
socio-economic determinants of health (e.g. contextual effects on
unemployment), particularly if looking at a regional level.

One of the problems (noted above) with contextual studies is that a very modest
increase in morbidity or mortality could be accounted for by numerous causal
factors. However, in instances of specific health issues where the causal factor is
already known, contextual studies may be useful. An example of this would be
to determine whether a higher instance of lead poisoning in a disadvantaged
location is related to the context of that suburb’s proximity to a lead smelter (and
this type of ecological study is quite common in epidemiology). The limitation
here, of course, is that any contextual effect observed will only be a very small
part of any overall contextual effect and, clearly, a miniscule contribution to any
health disadvantage associated with socio-economic disadvantage; the benefit
being a much better chance of identifying actual causal factors.

This multilevel approach to a specific issue was used in a study of food access in
Brisbane (Qld). This study examined whether access to food was affected by
where people lived and whether residency in a socio-economically
disadvantaged suburb impinged on their access to food, controlling for socio-economic factors. No contextual factors were found to have a significant impact on health, a finding in keeping with the fact that transport and shopping centres are widely accessible in that city.

Apart from the direct issue of health, there is also the issue of whether the socio-economic determinants of health disadvantage are affected by context. That is, to ask whether factors such as socio-economic disadvantage, sole parenthood or unemployment are themselves substantially influenced by location. Despite the fundamental importance of these factors as determinants of health disadvantage, they have not been extensively discussed within the location and health literature; specifically, the ways in which individual socio-economic position is influenced and maintained by location and how this in turn affects health status. The existence of this conceptual limitation led Robert to conclude that contextual effects on health have largely been underestimated.

Of course, once these associations are analysed more closely to determine their potential impact on health, there is likely to be only a small observable effect. Also, it would be expected that these studies are going to be subject to many of the same limitations as those discussed above (e.g. is the impact of locational disadvantage on employment a consequence of poor schooling, poor transport, suburb stigma, lack of local jobs, lack of access to job networks, etc?). However, given that the resolution of health disadvantage is largely an issue of reducing socio-economic disadvantage, the contextual effects on the socio-economic determinants of health are certainly worth examining (see Chapter 6).

Finally, it would appear that contextual studies would be of greater usefulness if they were 'contextualised' and that smaller study locations are not seen in
5. Does location matter? The relationship between location and health

isolation from wider regional and national settings. This is illustrated by the example of unemployment. Concentrated unemployment in a particular location has been shown to erode employment opportunities for people within that location (e.g. by reducing job seeking networks),[356] but employment may also be affected by job opportunities at a wider level. Unemployment can in fact be expected to be affected by regional unemployment trends,[347] for example as in the North of England or the western suburbs of Sydney. Variables at different levels are also likely to interact; for example, poor local transport could intensify the effects of regional unemployment or insufficient health services.

5.4 Conclusions

Location clearly does have a relationship to health disadvantage. This is largely due to the tendency of socio-economically disadvantaged households to be concentrated in particular locations, creating the so called 'compositional effect'. Some locations may also contribute a modest 'contextual effect', creating a small independent impact on health disadvantage. Compositional effects may provide a rationale for intervening locationally to address health disadvantage, but direct contextual effects probably do not.

At first glance, the fact that those suffering a health disadvantage tend to be concentrated in particular locations (for instance, as revealed through the rather alarming maps showing much higher rates of death and disease in the poorer parts of metropolitan areas of Australia[4]), would seem to suggest that, as the problem is locationally patterned, that is where remedial efforts should be focused.
5. Does location matter? The relationship between location and health

However, this supposition is only true to the extent that the:

- majority of health disadvantage is actually concentrated in these locations, and
- causes of the problems are capable of being addressed at locational level.

Compositional measures of health do not reveal either of these factors. Without also examining causes, composition is mainly useful as a crude measure of health inequalities.

A strong contextual effect of location on health could provide a clear rationale to intervene locationally, as it would indicate that some feature of location was having a negative impact on people’s health. However, there is little evidence to suggest that location has more than a modest effect on health, even in extremely disadvantaged locations such as those found in US cities.

The practical usefulness of discerned contextual effects is also limited by the degree of complexity involved. That is, the extreme difficulty in determining the causal processes behind contextual effects probably makes it impossible to design an intervention to address these effects. The problem is that these usually modest effects are themselves made up of many factors, the identity of which researchers must mainly guess. Compounding the confusion is the strong likelihood that the factors comprising contextual effects interact with one another and/or are collinear. In addition, location appears to work on different people in different ways. The possibility of gleaning useful information from this confusing mix, on which to base interventions, seems very low.
5. Does location matter? The relationship between location and health

Despite these problems, it was suggested that contextual studies may have some usefulness, for instance if applied to specific problems (e.g. food access) or to further the understanding of the socio-economic determinants of health. In the latter case it was considered that location may in fact exert a larger effect on the socio-economic determinants of health than health itself, on factors such as unemployment or sole parenthood. Thus, although the impact of such effects of health might ultimately be quite modest, they may possibly have a stronger effect on the creation and perpetuation of social exclusion and socio-economic disadvantage. These issues are returned to in the next chapter.

6.1 Introduction

This thesis has shown that the health gap between rich people and poor people is the result of the combination of material and psychosocial adversities through the lifecourse. It is apparent that the causes of this health gap are not evenly distributed across locations but are, as would be expected, concentrated in disadvantaged locations. Thus, for instance, unemployment, the number of low income earners and sole parents are higher in disadvantaged locations. This chapter focuses on:

- the relationship between social exclusion, the socio-economic determinants of health and location in urban Australia, and
- the implications of these factors for health disadvantage, and for the potential of a locational approach to address health disadvantage.

It was observed in Chapter 4 that in Australian cities there has been an increasing tendency towards segregation into rich and poor suburbs. The existence of disadvantaged locations could provide a rationale to address health disadvantage at a locational level – through locationally targeted health interventions and/or through locational interventions to address the processes of social exclusion that cause people to become socio-economically and health disadvantaged in the first place. This thinking provides, for example, the rationale for the locationally based approach to health disadvantage in the United Kingdom.[42, 341]

To determine the strength of this rationale for a locational approach to health disadvantage in urban Australia, three questions are used to guide the discussion:

- What has caused socio-economic and health disadvantage to become locationally concentrated in Australia?
- Are the causes of socio-economic and health disadvantage that are associated with location in Australia potentially able to be addressed though a locational approach?
- What proportion of the health disadvantaged population in Australia would benefit from a locational approach to address the causes of health disadvantage?

Before considering these questions, the chapter begins by presenting a model demonstrating the relationships between social exclusion, the socio-economic determinants of health, location and health disadvantage. The aim of presenting this model is to provide a visual summary of the conclusions of the previous chapters and to confer clarity to the complex causal pathways being considered in this chapter. This methodological approach is intended to provide a useful background for the discussion which follows in the rest of the chapter.
The chapter then discusses empirical research and theories which explain the:

- ways in which socio-economic disadvantage is locationally patterned in Australian cities
- reasons underlying this locational patterning
- possible associations between location and health disadvantage, and
- possible associations between location and the causes of health disadvantage.

This discussion focuses on a limited number of factors associated with health disadvantage *viz*:

- low incomes
- public housing
- unemployment
- sole parenthood, and
- locational disadvantage.

Clearly, a discussion of this nature could have included a range of other factors which are locationally patterned in urban areas and are related to (or are potentially related to) socio-economic and health disadvantage, such as concentrations of overseas born Australians, crime and violence, and provision of health services. However, the intentionally limited number of factors are sufficient to demonstrate the types of mechanisms involved in creating the locational dimensions of socio-economic disadvantage within the confines of a single chapter. These factors were selected because they can be considered to be
amongst the most important involved in the process of social exclusion (see Chapter 4) and in creating and concentrating socio-economic and health disadvantage in particular locations. Direct contextual effects on health disadvantage are not considered because at the time of writing there were no Australian studies of these effects (also, as discussed in Chapter 5, any contextual effects are likely to be very small).

The next part of the chapter involves a case study of the Sydney metropolitan area. It examines:

- the degree to which low income households are concentrated in Sydney by suburb
- the correlation between unemployment, sole parenthood and low income in Sydney suburbs, and
- the relationship between public housing and low income concentrations.

This quantitative study is included for a number of reasons. Although it is clear that poor locations are getting poorer, there is no published data on the concentration of low income households in Australian cities[377]; that is, data is not available to show how many poor people live in areas where a substantial proportion of other people are also poor. This inequality measure is used widely in the United States[84, 378, 379] and, for the purposes of this research, provides important information by showing where and how low income households are concentrated and the likely concentration of health disadvantage. It also gives some indication of how many health disadvantaged households would be reached through a locational approach.

6.2 A causal model

Location is not the principle determinant of social exclusion, socio-economic disadvantage or health disadvantage (see Chapters 4 and 5); it does, however, reflect, and can reinforce, social exclusion and the disadvantages experienced by socio-economically disadvantaged people. The model below (Figure 5) demonstrates where location is placed in relation to the processes of social exclusion and the creation of socio-economic and health disadvantage (it was established in Chapter 4 that social exclusion incorporates both the causes of and the states associated with socio-economic disadvantage).

Starting with health disadvantage, it is evident that exposure to socio-economic disadvantage across the life course and the factors causing social exclusion (Box A) are the main determinants of health disadvantage, regardless of location (thick arrow to Box C). A modest additional contextual burden on health can result from living in a disadvantaged location (arrow from Box B to Box C). Contextual factors can also compound social exclusion and socio-economic disadvantage (arrow from Box B to Box A) and hence contribute to the continuing health disadvantage suffered by socio-economically disadvantaged populations.

In regard to disadvantaged locations (Box B) – it is evident that they are a consequence of the concentration of the factors associated with social exclusion and socio-economic disadvantage including unemployment, sole parenthood, and insecure and low paid employment (Box A). Socio-economic disadvantage becomes concentrated in disadvantaged locations through the mechanisms of housing markets, the location of public housing and the changes of regional employment markets (in particular manufacturing) (see Chapter 4) (arrow from Box B to Box A).

**Figure 5.** Social exclusion, socio-economic disadvantage, location and health disadvantage

- **Disadvantaged locations** can create and compound social exclusion - through excess unemployment, poor services, lesser quality education.

- **Housing markets and the location of public housing** sorts households into different suburbs. Uneven job loss affects some locations to a greater extent.

- **Location** can exert a modest additional burden on health.

- **The socio-economic determinants of health** are the main causes of health disadvantage. The longer the exposure the worse the outcome. Disadvantage is compounding and reduces resistance to further adversity.

6.3 The distribution of low income households in Australian cities

Each Australian city has always had identifiably richer and poorer locations, but since the 1970s the average income of poorer suburbs has been falling, while the average in wealthier suburbs has been increasing.[33, 380, 381] Between 1976 and 1996 the inequality between Australian neighbourhoods increased 40% as measured by changes in the gini coefficient\textsuperscript{11}.[33] Even though Australia is probably still a long way from replicating the type of deeply troubled urban ghetto found in the United States, in each Australian city there are identifiable disadvantaged locations. These locations are creating concern amongst policy makers, politicians and academics as they are seen as further disadvantaging the people who live there by limiting their employment and educational opportunities.[382-384] They are also viewed, with some justification, as experiencing elevated levels of crime, violence and generational welfare dependency.[383, 385]

In 2003 a Social Atlas for each Australian city was produced by the Australian Bureau of Statistics, containing maps of a range of demographic variables for each from the 2001 census.[386-393] These maps show that in each city there are numbers of collector districts (containing around 200 households) with a sizeable minority of households earning low incomes\textsuperscript{12}. Examining the maps shows quite clear spatial concentrations of poorer collector districts in Sydney, Melbourne, and Brisbane, where they tend to be clustered together. For instance, Sydney collector districts with 25% or more of households on incomes less than

\textsuperscript{11} The gini coefficient is a widely used measure of income inequality (see Chapter 2).

\textsuperscript{12} The Social Atlases (apart from Adelaide) use the figure of under $400 per week roughly equivalent to the bottom 2 income quintiles. Inexplicably, the Adelaide atlas uses the cut-off of under $300 which, given that Centrelink payments for an unemployed couple or a sole parent with only one child exceed this amount, seriously undermines the accurate mapping of low income households in this city.

$400 per week are concentrated in the western and outer western suburbs of Sydney. In Perth and Adelaide the clustering of low income collector districts is not as clear cut, although there are identifiable areas in different parts of each city where these households are concentrated. In the case of Adelaide the lack of a clear pattern may be due to the low cut-off figure of $300 per week or less (see footnote 12).

Although there is by no means an exclusive divide, and many poor households are in suburbs were most or even a sizable percentage of other households are not poor (an issue returned to below), even a degree of residential segregation by income has some potential implications for understanding socio-economic and health disadvantage.

6.3.1 The reasons for disadvantaged locations
Disadvantaged locations are associated with high numbers of people receiving low incomes; for example, unemployed people, sole parents, people in insecure part-time and insecure employment and retired people. And, clearly, a disadvantaged location is by definition one in which socio-economically disadvantaged households are concentrated.

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13 It is important to note that people in this last category may not be socio-economically disadvantaged and this can distort the impression of a spatial inequality. In Perth, for instance, some of the highest concentrations of low income households were associated with numbers of people aged over 60 many of whom are retired and own their homes outright, hence a low household income is unlikely to place them in poverty. Australian Bureau of Statistics. (2003). 2001 Census of population and housing: Perth a social atlas. Canberra: ABS.

It is also important to recognise that there are a range of processes which contribute to the creation of disadvantaged locations (see also Chapter 4), including:

- the 'sorting' of people into locations with cheaper housing (for instance, when people obtain tenancy in public housing or move to areas with cheaper rents)
- the erosion of relative incomes in particular locations, and
- contextual factors which mean that people are more likely to have a low income, be unemployed or a sole parent if they live in a particular suburb.

A consideration of the reasons for the development of disadvantaged locations is important in this thesis, as some causes might potentially be ameliorated at locational level, while others clearly cannot. First, it needs to be recognised that, in terms of understanding health disadvantage, the sorting of people into high and low cost suburbs need not be a concern in itself, provided services and opportunities are equal across locations; for instance, if schooling, access to jobs and health services did not vary by location. In addition, all other things being equal, if the growth of poorer locations is largely a consequence of declining relative incomes of lower income groups (i.e. a growing wealth gap), then this is a macro issue which may be addressed through intervention in wages, taxes and transfers; it also, more cynically, could be viewed as being functional to maintaining profit levels for business enterprises (see Chapter 4). However, location is clearly important if residential segregation is associated with reduced opportunities, health damaging exposures and an increased chance that a person will be poor, remain poor or become unemployed or a sole parent. The following sections discuss these issues in relation to Australian cities.

6.3.1.1 Public housing

The areas of most concentrated disadvantage in Australian cities are those in which there is a high density of public housing – this occurs as public housing tenants are overwhelmingly welfare recipients.[394, 395] In all states, measures have been taken to break down large public estates and reduce the density of housing department properties, most notably in South Australia, Queensland and Western Australia,[49, 396] with similar measures planned for New South Wales[49] (at Minto, for instance, and with proposals for Mt Druitt [see Chapter 8]). However, large scale housing estates are still in existence in NSW, for instance, around a third of public housing is in this category (approximately 42,000 dwellings)[397]p.4.

From a social justice perspective, the provision of low cost housing by the government for welfare recipients is a desirable initiative. Indeed, one of the main problems with public housing is that there is not enough to meet demand; critics have pointed to lengthy waiting lists and substantial government disinvestment in the public housing sector in favour of providing private rental assistance.[398] The fact that public housing in Australia is associated with a wide number of social problems[399] and health disadvantage[400] is largely a reflection of compositional effects. However, the fact that public housing also features poor urban design and planning and high density socio-economic disadvantage means that the housing configuration conceivably contributes to additional contextual burdens on socio-economic status and health.

The existence of large public housing estates in Australia is generally viewed as problematic, even within state housing departments.[397] When this housing was first built, during the manufacturing booms of the 1960s, it was designed to provide large areas of low cost housing for blue-collar workers. However, the subsequent transition of this worker housing to welfare housing has created a
high density of people with very low incomes and a strong demand for support services. Some of these estates have been located in areas of high unemployment and/or low infrastructure levels. Many also feature poor urban design, which can contribute to a lack of privacy, and potentially encourage crime (see below).

Public housing estates have a number of links to the determinants of health disadvantage, mainly as a consequence of a high concentration of disadvantaged people; for example, disability pensioners, sole parents and the long term unemployed. This housing is also used as priority housing for people in crisis, including people who are mentally ill, teenage mothers, recently released prisoners and women escaping domestic violence. The overwhelmingly disadvantaged population means there is a higher demand for medical and mental health services. There is also a higher incidence of problems which are correlated with low income and damage health, including substance abuse, domestic violence, and child abuse and neglect. Health outcomes tend to be poor: Wiggers and colleagues' study of health outcomes amongst public housing tenants found worse self-rated health, more frequent use of health services, higher rates of smoking, higher prevalence of falls, greater risk of injury due to violence and six times the risk of injury due to domestic violence.

There are, additionally, a number of contextual issues faced by residents in public housing. These are issues that are a function of estate living: for example, crime and locational disadvantage. Public housing tenants are also at risk of 'poverty trap' disincentives to gaining paid employment (see below).

Crime rates tend to be higher in public housing estates, but mainly for reasons of composition. Only small contextual effects have been identified and
there is no clear evidence that any particular public housing design contributes to excessive levels of crime beyond what would be expected.[395, 404] However, the propensity of people on low incomes to commit more crime[385] means that it might be expected that residents in public housing estates are also exposed to higher levels of crime than if they lived in more income mixed locations. It is also possible that, even if particular public housing designs do not facilitate crime, they may make residents feel more vulnerable to crime; for instance, one of the results of urban renewal has reportedly been to decrease residents’ fear of crime (e.g. through the closure of rear access laneways behind houses – see Chapter 8). Health can be eroded by fear of crime, [187, 405] which is a function of actual crime and perceived vulnerability to crime. So, in this sense, public housing estates and the design of public housing do potentially contribute to a contextual effect on health.

Some public housing estates, most notably those in the outer suburban areas, suffer from distinct locational disadvantage, relating, for example, to lack of transport, shops and limited facilities. Also, parts of otherwise well serviced estates may suffer from deficient services. This problem is illustrated in the Mt Druitt area, NSW: southern suburbs are located close to a train station, bus interchange and a large shopping complex, whilst those at the area’s outskirts (containing the highest density of public housing and lowest rates of car ownership) have access only to infrequent bus services, limited shopping facilities (and, in some suburbs, no shopping facilities) and very sparse community amenities (see Chapter 8). An additional problem is the distance of some of these suburbs from employment, compounding the disadvantage of those who are unemployed.

Another disadvantage specific to public housing is that there is potentially a disincentive for residents to get jobs because of the resultant loss in rental

Rent is paid as a percentage of income, so that as income rises so does rent; this mechanism does serve to shift employed people out of public housing, but also creates a high effective marginal tax rate (EMTR) as tenants face a combined loss of the rebate and other social security benefits. In this sense, public housing contributes to a 'poverty trap' by reducing the financial rewards of gaining employment. Hulse and Randolph estimated that public housing tenants would face an EMTR of between 85% and 105%, presenting, in theory, "an overwhelming workforce disincentive for this group."[406]p.27.

On the other hand, despite the problems associated with public housing, there are decided benefits from this form of tenure compared to renting privately. Tenants are protected from housing stress (when housing costs exceed 30% of income[398]), as they pay a fixed proportion of their income; virtually all public housing tenants could expect to pay more than 25% of their income if they were to enter the private rental market.[407] This is a particular advantage for tenants who can expect to remain on a low fixed income for long periods of time; for example, sole parents and aged and disability pensioners. In fact, comparisons of private and public tenants show that private tenants are substantially worse off financially.[406] Public housing is also a very secure form of tenure, due to fixed rents and because tenants (generally) do not have to be concerned that their home will be sold and that they will be forced to move.

Many of the other problems faced by residents of large public housing estates are shared by other welfare recipients and low income earners located in the outer suburbs of the major cities and depressed regional cities, including unemployment and the compositional effects created by the co-location of high numbers of socio-economically disadvantaged people (see below).

6.3.1.2 Unemployment

There is a tendency for jobless people to be locationally concentrated, either through the location of public housing (see above), through self sorting (people lose their jobs and the consequent drop in income forces them to move to a cheaper suburb) or because of the particular vulnerability of certain populations to joblessness. In addition, the existence of contextual factors at locational level can increase the chances of joblessness, for example, lack of jobs in a region or poor transport links. Furthermore, contextual factors can compound existing labour market disadvantage. The implication of locationally concentrated joblessness and contextual contributions to unemployment is that targeted locational interventions may be appropriate to address the issues. These may also be expected to have an eventual positive impact on health disadvantage.

Poorer locations in Australia tend to suffer higher rates of unemployment in general and are more susceptible to the effects of recession. By contrast, wealthier locations with relatively low rates of unemployment display less cyclical sensitivity to changes in unemployment rates. The unemployment rate during the 1970s was fairly uniform across ABS Census collector districts (CDs), but began to widen markedly with each economic recession; for instance, in 1991 unemployment rates ranged from 5% to 37% between CDs. One of the characteristics of social exclusion is the insecurity of employment for socio-economically disadvantaged people – reflected in these figures.

The collapse of manufacturing industries which created 'rust belts', with higher than average unemployment in some working class suburbs, was discussed in Chapter 4. Indeed, historic high unemployment rates in low income locations have been largely attributed to the disproportionate numbers of manufacturing industry employees in these locations. People with lower educational

attainment are also more susceptible to fluctuations in the employment market,[409] a group also over-represented in disadvantaged locations.

Although unemployment rates are historically very low (at the time of writing), residents in poorer outer suburbs remain vulnerable to swings in the employment cycle; for instance, the employment market intersects with the affordable housing market – with mismatches between employment growth areas and the outer suburban areas of lower cost housing.[406, 408, 411] Dodson also reports that in Melbourne there is an employment market divide of ‘old economy’ and ‘new economy’ jobs which parallel the suburban income divide.[408]

Contextual factors (characteristics of neighbourhoods) appear to have a substantial effect on the unequal distribution of unemployment; for instance, Hunter’s analysis of differences in unemployment rates between low and high status CDs found that, after accounting for the differences between individuals, 20 percent of the difference in unemployment rates was due to neighbourhood characteristics.[410] In contrast to contextual effects on health disadvantage (see Chapter 5), it seems that there is a greater likelihood of identifying contextual effects on unemployment, given relatively more straightforward causal pathways (it was established in Chapter 5 that the causes of contextual effects on health probably cannot be determined). Borland suggests that some of the contextual reasons for differences between neighbourhoods may include transport, quality of schooling (which varies with average income of an area), lack of employed or highly educated role models, limited job referral networks and a culture of early school leaving.[409]

Borland’s assertions are supported by international research (e.g. [289, 412]) and a limited number of Australian studies that examine contextual effects on

employment and educational outcomes (for an overview see [413]). Although it is beyond the scope of this thesis to explore this research in depth, it is useful to visit some of the contextual issues here.

Within educational sociology there has been a strong current demonstrating how schooling serves to reproduce class differences.[215, 414, 415] These researchers argue that schools in disadvantaged locations offer a qualitatively different education and serve to alienate students from the educational process, consequently school leavers are ill-equipped for anything but the lowest paid jobs. More recently, Thomson’s study of schools in the disadvantaged northern suburbs of Adelaide found that the education offered was inferior to that offered by private schools and by other state schools in more affluent locations;[203] a particular problem was the amount of time staff had to devote to resolving welfare issues, to the detriment of the education they could offer. There is also some Australian evidence to suggest that neighbourhood can affect early school leaving rates.[416] Clearly, there is great potential to investigate these issues in more detail, to determine in particular whether falling investment in public education in some Australian states and the exodus of wealthier families to private schools is having an adverse impact on educational outcomes of students in disadvantaged locations.

Another type of contextual effect is created by the size of job networks. When the number of contacts an individual has falls below a certain threshold, their chances of gaining employment are massively reduced. Thus, even when no discrimination is practiced, socially excluded workers fail to get jobs, which go to less able workers who are better placed in the referral network.[289] In addition, it has been observed that when workers realise that they have no probability of being referred to a job they no longer invest in job training.[289] Similarly, an Australian study examining contextual effects of neighbourhood

on youth employment hypothesised that the negative effect of living in a poorer neighbourhood was due to lower numbers of people with vocational qualifications and hence weaker employment networks.[413]

6.3.1.3 Sole motherhood

The number of sole mother families in Australia have risen markedly over the past two decades, forming 15.4 percent of families in 2001,[417] an increase from 8.8% in 1991. (1991 CENSUS) Sole parent families are at higher risk than couple families of living in relative poverty, with 22% living below the poverty line compared to 13% of couple families.[328] Like other indicators of social exclusion, sole mothers tend to be concentrated in certain locations; for example, in 1996 17% of women in Campbelltown aged 25-29 were sole parents compared with 5% in the category 'Rest of Sydney'.[325]p.65. In Australia, sole mothers are concentrated in the outer suburban areas of cities and regional towns, where housing is more affordable.[325] They are also disproportionately represented in public housing, forming 25% of tenants overall for this form of tenure,[417] and up to 43% of new tenants in some states.[418]

There are two main hypotheses to explain the concentrations of sole mothers in particular locations: 'home grown' and 'migration related'.[325] The first hypothesis suggests that higher numbers of sole parents in a location is a consequence of the characteristics of the location itself (i.e. contextual), the second suggests that single mothers tend to move to areas where housing costs are low or are left behind when more well off residents move away. In Australia, there is evidence that both types of factors influence the location of sole parents.

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14 The term 'sole mothers' is used as the vast majority of sole parents are female and most research focuses on sole mothers.

In Chapter 4, the clear relationship between unemployment and marital breakdown in the depressed northern regions of England was presented. No similar study has been conducted in Australia, although low income males are more likely to be divorced or separated.[419] In addition, Birrell and Rapson's study of the causal pathways to female sole parenthood shows that the rising numbers of sole mothers amongst disadvantaged populations is related to poor economic circumstances and limited economic prospects in a location.[325] Their analysis applies particularly to sole mothers who have never been married, a group who are, in general, more disadvantaged because they are less likely to have assets to draw upon (from the marriage) and more likely to have an ex-partner who is unable to pay child support.

US researcher Abrahamson argues that the explosion in numbers of sole mothers in poor American suburbs is strongly related to the declining economic situation for males.[420] For disadvantaged women, becoming a sole parent occurs as a more reasonable option than marriage to a man with few job prospects. In Australia, it appears that a similar trend may be occurring – albeit on a smaller scale – with a correlation between concentrations of males on low incomes and concentrations of sole mothers in outer suburbs and depressed regional areas.[325]

These high levels of sole parenthood are also associated with higher levels of early school leaving, suggesting a further link to economic disadvantage (e.g. if there are few jobs, staying on at school may seem pointless).[325] Even though this research is still developing, it does suggest that increases in the number of sole mothers in this situation do not appear to be primarily welfare driven but created by a lack of opportunities for young people in particular locations.

Sole mothers are a relatively mobile group (compared to two parent families) but move mainly within cities: for instance, from the middle suburbs to the cheaper outer suburbs of cities, areas which have characteristics likely to 'promote sole parent status'. Rapson and Birrell found that migration related factors accounted for only a small proportion of increased numbers of sole mothers in the areas outside cities. This is an indication that the popular conception of sole mothers moving to cheaper coastal and regional areas is inaccurate. However, these trends may change, at least in Victoria and NSW, given large increases in median rents in these cities.

6.3.1.4 **Locational disadvantage**

It has already been shown that location can be a disadvantage when it comes to seeking employment, however disadvantaged locations do not need to lack infrastructure and services (the absence of which can be the source of a further contextual burden on the health and opportunities of local residents). For example, if each neighbourhood provided good health services, shops and facilities, equal education and employment opportunities and transport, then where a person lived (purely as a location) should not disadvantage them further, either in terms of their immediate health needs or in perpetuating social exclusion. Hunter, in his analysis of spatial inequality, distinguishes between inequality (the existence of rich and poor locations) and locational disadvantage (disadvantages specific to a location) which he argues can also affect non-poor locations. This differs from the definition used by Vinson in which indicators of disadvantage are considered together (e.g. unemployment, child maltreatment and education) as 'cumulative disadvantage', and used as the basis for an index of locational disadvantage.

Although both sets of issues are important and often inter-related, it is useful to consider locational inequality (rich and poor locations) and locational

disadvantage (location specific disadvantage) separately, because identifying what is actually detrimental about a location offers potential intervention points, whilst locational inequality, does not necessarily in itself. In actuality, locational inequality in Australia is often, although not always, accompanied by locational disadvantage. This is particularly the case as most of Australia’s poorer suburbs, unlike those in most other affluent nations,[84, 408] tend to be located in the outer, poorly serviced suburban areas of the major cities\(^\text{15}\). A 1991 study found that locational disadvantaged areas in Australia featured:

- inadequacies in the regional or urban planning and development process
- poor public transport
- limited regional employment opportunities
- failure to match service provision to population growth, and
- general service delivery problems.[421]

More recent research shows that these problems have been persistent, certainly for the periphery suburbs of Australian cities. Difficulties in public transport, poor match between worker and employment location and insufficient services to meet population demand are all in evidence.[302, 383, 408] Also, these problems look set to continue and affect new populations in the future, particularly in view of the trend to place large new low cost housing developments on the outer areas of the cities. In Perth (WA) for example, the large Ellenbrook estate was built with little access to services and transport, and a public housing estate has been proposed for Amarillo, 60 kms south-east of the

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\(^{15}\) Poorer inner city suburbs such as Waterloo in Sydney are mainly poor by virtue of high density of public housing.

Similar developments can be observed on the outer areas of other Australian cities.

Although locational disadvantage can affect disadvantaged and non-disadvantaged locations, its effects are likely to be felt disproportionately by socio-economically disadvantaged people; for example, if they do not have a car and public transport is inadequate, or if they do not have income sufficient to compensate for higher prices in the small local shops (as compared to the prices in chain supermarkets). An examination of rates of car ownership across Sydney's outer suburbs (those without access to rail or full time bus service) shows distinct variations by suburb. Poorer suburbs have far higher rates of carless households; for example, 30% of households in Miller (western Sydney) do not have access to a car, compared to 3% in Glenmore Park (western Sydney). Similarly, a study of Melbourne areas, which divided them into 'transit rich' (well serviced by public transport) and 'transit poor' (poorly serviced by public transport), found that the transit poor areas were also more socio-economically disadvantaged.

6.3.2 The dimensions of locational disadvantage

Although it is possible to observe general patterns in locational disadvantage across Australian cities, disadvantage can vary quite markedly, even between locations that are equally poor. Some very poor areas appear unlikely to suffer from a full range of locational disadvantage; for instance, in Western Australia the postcode with the highest poverty rate in the State, at 19% (using Henderson half average), was Perth City, a well serviced area with low unemployment. Locations may also be disadvantaged in one aspect but not others: Turrell and colleagues' study of food access in Brisbane, found that, on average, living in a poorer suburb made no significant difference to food access

or what type of food was consumed, with individual factors accounting overwhelming for any differences.[355]

Clearly, factors such as high unemployment in a region will affect a range of residents across that region, but other factors, such as a lack of transport, may affect only a suburb or parts of a suburb. Even micro level disadvantages can potentially adversely affect people, particularly if they have no car; for instance, if there was a lack of play facilities for children. For these reasons, studies of locational disadvantage using statistical local area (SLA – roughly equivalent to Local Government Areas) as a unit of analysis have been criticised as being too large to capture the nuances of disadvantage.[422] (SLA was used as the spatial measure in the Local Area Research Studies (LARS) project (see above)[421] and Community Opportunity and Vulnerability in Australian Cities and Towns[424]). It would appear that contextual studies of health or socio-economic disadvantage intending to capture the effects of locational disadvantage across a range of suburbs are at risk of missing location specific disadvantage; for instance, there may be some isolated suburbs in Brisbane (see Turrell’s study, above) in which food access is a problem.

Another locational disadvantage that potentially burdens residents is that of 'suburb stigma', where the bad reputation of a location can result in employment discrimination or negative stereotyping. This perception of locations as 'hot beds' of crime and drug abuse, sometimes fuelled by the media and, ironically, the well intentioned labelling of certain areas as 'disadvantaged' by policy makers and researchers can "further stigmatise and alienate their residents."(Powell 1993 in [302]) (and see Chapter 8).

6.4 The locational divide: Sydney case study

The previous sections of this chapter have discussed some of the ways in which the socio-economic determinants of health disadvantage are patterned by location. This section presents a secondary data analysis of household incomes in the Sydney metropolitan area, using data from the 2001 Census. It shows the extent to which low income households are concentrated by suburb, the correlation between unemployment and sole parent rates by suburb and the relationship between public housing density and low income suburbs. The purpose of this analysis within the larger piece of research is threefold:

1) To provide an indication of what proportion of low income households would potentially benefit from interventions targeting disadvantaged locations (recognising the number of limitations of the data that is used).

2) To determine if there is a correlation between unemployment and sole parenthood. A strong correlation of these two important determinants of social exclusion, socio-economic and health disadvantage supports the possibility that they are possibly causally related and/or tend to vary together due to low cost housing or contextual factors. In either case, a strong correlation of unemployment and sole parenthood by location would indicate an intensity of need for health and other services in such locations, given the disadvantages both these groups face.

3) To show the extent to which low income suburbs are related to high density public housing. This relationship can indicate the extent to which disadvantaged locations are a creation of public housing.

policy, i.e. an artificial creation of government decisions concerning the location and densities of public housing.

6.4.1 Measuring poverty: what is poor, what is a disadvantaged location?

The analysis uses a measure similar to that developed by US researcher, Jargowsky.[84, 333] This measure classifies high poverty areas (US census tracts) as those containing 40% or more households in poverty. Its purpose is to indicate the degree of residential segregation by income and where low income households are located. It also makes possible the determination of the proportion of the total population of households earning low incomes in locations where there is a concentration of these households. Thus, as discussed above, it enables a consideration of the question of the efficacy of a locational approach where interventions are targeted at low-income locations.

In this analysis, the threshold figures of 40% and 33% household income concentrations are used for very low (<$400), low (<$500) and vulnerable (<$600) income groupings. The lower threshold of 33% is used in this analysis, as there are actually very few suburbs in Sydney (7 in total) in which the density of very low incomes exceeds the 'Jargowsky threshold' of 40%. Of course, this could be expected given the higher rates of poverty and poverty concentration in the United States and the greater heterogeneity of Australian suburbs.[425]

6.4.2 Method

A range of measures were taken at suburb level for 461 Sydney suburbs. Suburbs were included provided they contained over 400 households; smaller suburbs were excluded on the basis that they may produce sampling errors. Households which provided negative, nil, partial income data or no income data were excluded from the analysis. Measures include:

- percentage of households earning an income less than $400 gross per week (denoted 'very low income')
- percentage of households earning an income less than $500 per week (denoted 'low income')
- percentage of households earning an income less than $600 per week (denoted 'vulnerable')
- sole parent families as a proportion of total families
- unemployment rate, and
- percentage of households without cars.

These household income categories are taken from the income bands used by the ABS in 2001. However, there are a number of difficulties associated with using ABS census data which the use of three different categories attempts to overcome, at least in part. The main problem is that income is not sorted by household size or housing costs, both of which can influence whether or not a household is in relative poverty. Poverty line thresholds vary from $278 per week for a single person to over $672 per week for a couple family with 4 children.[426] Housing costs range from nil, through to subsidised (as in public housing) to a large percentage of income (median rent for a 3 bedroom dwelling

in Sydney ranges from $450 per week in inner Sydney to $230 per week in the outer suburbs\[402\]). Thus, any threshold figure may result in the inclusion of households that have quite different disposable incomes after housing costs. For this reason, expenditure measures of poverty are often used in addition to income only measures;\[255\] for instance, being able to afford socially perceived necessities (see Chapter 4). However, in the absence of this data at locational level, the use of three different income bands aims to give an indicative measure of where low income households are concentrated and to include the majority of such households. It also aims to include households which, although not currently socio-economically disadvantaged, may be vulnerable to the processes of social exclusion. These figures should be seen as including those in the category described by Byrne as 'vulnerable to social exclusion' (see Chapter 4); for instance, households on or near to poverty line incomes are particularly vulnerable to negative effects from housing cost increases and job loss.

The first category 'under $400 per week' is used in line with that used by the ABS Social Atlases (see above). However, it should be noted that Centrelink payments exceed this amount for couple families with one or more children (with the family head not in the labour force), or two or more children (with family head in the labour force), and sole parent families with three or more children.\[427\] Thus, most families in these categories will not be included under this cut-off. The other two categories of $500 and $600 gross per week will include most households living in relative poverty in Sydney, but will tend to overestimate the incidence of these households.

6.4.3 Data analysis

The data was initially tabulated on a spreadsheet using the software Excel. Using online data of the ABS 2001 Census, each Sydney suburb with over 400 households was listed. Numbers of households in the income bands ($400, $500,

$600) were calculated for each suburb, and the proportion of the suburb’s households in each income band was determined. Sole parent family rate for each suburb was determined by sole parent families as a proportion of all families for that suburb. The unemployment rate for each suburb was taken directly from the Census figures. 'Lack of a car' percentages were determined by numbers of households with no car as a percentage of all households in that suburb. Public housing rates were determined by number of households renting from a public authority as a percentage of all households in that suburb.

Correlations were performed using the statistical software Stata (version 8.2). This process involved transferring the data for sole parents, unemployed and percentages of households in the under $400 band for each suburb to Stata. Simple correlations were determined for these variables (sole parents/percentage of households<$400, unemployment/percentage of households<$400, sole parents and unemployment), using Pearson's rho (which reflects the degree of linear relationship between two variables).

6.4.3.1 Data and data limitations

The data used in this analysis is aggregate data published by the ABS. As this data does not include linked unit records, it is not possible to determine whether the same households are experiencing a range of disadvantages (e.g. low income, no car and unemployment) or whether they are disadvantaged over time. In addition, it is not possible to determine the size of households in each income bracket or whether low income households own their home; each of these factors can influence whether the people living in a household should be considered to be living in relative poverty or not. Thus, the results of this analysis should be taken as an indicator of the locational dimensions of social exclusion and socio-economic disadvantage – as reflected by concentrations of

low income households, unemployed people and sole parents – rather than a definitive measure.

The study uses the locational dimension of ‘suburb’. Within cities, a range of different sized locations could have been selected, for example there is ABS household data at the levels of collector district, suburb and LGA. Suburb level data was used because this thesis is investigating the issue of intervening locationally. Suburbs are usually sufficiently large and have characteristics that would enable interventions to feasibly be implemented within them or within suburban clusters (e.g. suburbs are usually the location of particular services and amenities, such as schools, shops and transport). Collector districts are much smaller units (the smallest geographic area defined by the ABS) and it would not normally be feasible to focus interventions at such a small level. By contrast, LGAs are much larger areas containing numbers if suburbs. However, it was noted in Chapter 5 that LGAs can ‘hide’ disadvantage; the existence of both wealthier and poorer suburbs gives a higher average income and can disguise concentrated socio-economic disadvantage. Thus, taking the above factors in to account, suburbs were considered the optimum level at which to assess the level of concentrated urban disadvantage.

6.4.4 Results

6.4.4.1 Concentration of households by income

The following three tables present the concentrations of low incomes households by suburbs using the three thresholds used in the analysis: 'very low income' (<$400), 'low income' (<$500), and 'vulnerable', (<$600).

Table 1. Sydney suburbs: concentration of very low income households (<$400)

<table>
<thead>
<tr>
<th>&lt;$400 threshold</th>
<th>Number of suburbs</th>
<th>&lt;$400 households</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>40%</td>
<td>7</td>
<td>2%</td>
<td>There are 7 suburbs where more than 40% of households earn less than $400 per week. 2% of Sydney's very low income households are in these suburbs.</td>
</tr>
<tr>
<td>33%</td>
<td>21</td>
<td>7%</td>
<td>There are 21 suburbs where more than a third of households earn less than $400 per week. 7% of Sydney's very low income households are in these suburbs.</td>
</tr>
</tbody>
</table>

Table 2. Sydney suburbs: concentration of low income households (<$500)

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Number of suburbs</th>
<th>Number of &lt;$500 households</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40%</td>
<td>25</td>
<td>8%</td>
<td>There are 25 suburbs where more than 40% of households earn less than $500 per week. 8% of Sydney’s poor households are in these suburbs.</td>
</tr>
<tr>
<td>&lt;33%</td>
<td>78</td>
<td>28%</td>
<td>There are 78 suburbs where more than a third of households earn less than $500 per week. 28% of Sydney’s poor households are in these suburbs.</td>
</tr>
</tbody>
</table>

Table 3. Sydney suburbs: concentration of vulnerable households (<$600)

<table>
<thead>
<tr>
<th>Threshold</th>
<th>Number of suburbs</th>
<th>Number of &lt;$600 households</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>40%</td>
<td>65</td>
<td>23%</td>
<td>There are 65 suburbs where more than 40% of households earn less than $600 per week. 23% of Sydney’s poor and vulnerable households are in these suburbs.</td>
</tr>
<tr>
<td>33%</td>
<td>126</td>
<td>42%</td>
<td>There are 126 suburbs where more than a third of households earn less than $600 per week. 42% of Sydney’s poor and vulnerable households are in these suburbs.</td>
</tr>
</tbody>
</table>

6.4.4.2 Unemployment, sole parenthood and low incomes

Figures 6 to 8 show, by suburb, the correlation between the:

- percentage of very low income households (<$400) and the unemployment rate (Figure 6)
- percentage of very low income households (<$400) and the percentage of sole parent households (Figure 7), and
- unemployment rate and percentage of sole parent households (Figure 8).

It is apparent that the concentration of low income households is highly correlated with the unemployment rate of the suburb (0.71 Pearson’s $r$) and the proportion of families who are sole parent families (0.79 Pearson’s $r$).

**Figure 6.** Relationship between low income households and unemployment rate (by Sydney suburb).

**Figure 7.** Relationship between low income households and percentage of sole...

There is also a high correlation between unemployment and sole parents as a proportion of families in each suburb, with unemployment rates and proportion of families who are sole parents tending to increase together (0.79 Pearson’s rho).

Figure 8. Relationship between unemployment rate and percentage of sole parent families (by Sydney suburb).

6.4.4.3 Public housing and density of very low income households

Table 4 lists Sydney’s 40 poorest suburbs as ranked by concentration of very low income households. It shows for each of the 40 suburbs the percentages of:

- households with income less than $400/week
- sole parent families
- unemployment rate
- public housing
- households with no car
- average household size, and
- average age.

Table 4. Sydney’s poorest suburbs (ranked by concentration of incomes <400 [%]).

<table>
<thead>
<tr>
<th>Rank</th>
<th>Suburb</th>
<th>&lt;$400</th>
<th>Sole parents</th>
<th>Unemp.</th>
<th>Pub. housing.</th>
<th>No car</th>
<th>Average household size</th>
<th>Average Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Sydney Average)</td>
<td>18.0</td>
<td>15.0</td>
<td>6.6</td>
<td>6.0</td>
<td>14.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Waterloo</td>
<td>63.9</td>
<td>46.2</td>
<td>19.6</td>
<td>81.8</td>
<td>61.9</td>
<td>1.8</td>
<td>45</td>
</tr>
<tr>
<td>2</td>
<td>Daceyville</td>
<td>55.5</td>
<td>42.6</td>
<td>8.9</td>
<td>75.7</td>
<td>45.2</td>
<td>2.0</td>
<td>47</td>
</tr>
<tr>
<td>3</td>
<td>Airs</td>
<td>50.8</td>
<td>50.5</td>
<td>30.1</td>
<td>92.0</td>
<td>32.4</td>
<td>3.3</td>
<td>23</td>
</tr>
<tr>
<td>4</td>
<td>Claymore</td>
<td>50.6</td>
<td>54.6</td>
<td>35.9</td>
<td>88.4</td>
<td>35.6</td>
<td>3.4</td>
<td>20</td>
</tr>
<tr>
<td>5</td>
<td>Cartwright</td>
<td>47.0</td>
<td>29.1</td>
<td>18.3</td>
<td>43.1</td>
<td>34.1</td>
<td>2.6</td>
<td>35</td>
</tr>
<tr>
<td>6</td>
<td>Villawood</td>
<td>43.9</td>
<td>30.9</td>
<td>17.2</td>
<td>52.7</td>
<td>28.4</td>
<td>2.8</td>
<td>35</td>
</tr>
<tr>
<td>7</td>
<td>Miller</td>
<td>42.6</td>
<td>31.7</td>
<td>10.2</td>
<td>50.0</td>
<td>29.9</td>
<td>2.8</td>
<td>38</td>
</tr>
<tr>
<td>8</td>
<td>Riverwood</td>
<td>39.5</td>
<td>21.8</td>
<td>9</td>
<td>36.1</td>
<td>28.2</td>
<td>2.5</td>
<td>38</td>
</tr>
<tr>
<td>9</td>
<td>Ashcroft</td>
<td>38.5</td>
<td>27.5</td>
<td>18.1</td>
<td>35.7</td>
<td>23.8</td>
<td>3.0</td>
<td>32</td>
</tr>
<tr>
<td>10</td>
<td>Warwick Farm</td>
<td>37.7</td>
<td>28.4</td>
<td>18.4</td>
<td>31.6</td>
<td>34.3</td>
<td>2.4</td>
<td>33</td>
</tr>
<tr>
<td>11</td>
<td>Bidwill</td>
<td>37.0</td>
<td>44.6</td>
<td>22</td>
<td>69.1</td>
<td>27.1</td>
<td>3.3</td>
<td>25</td>
</tr>
<tr>
<td>12</td>
<td>Sadleir</td>
<td>35.6</td>
<td>27.7</td>
<td>16.4</td>
<td>38.1</td>
<td>21.0</td>
<td>3.0</td>
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</tr>
<tr>
<td>13</td>
<td>Millers Point</td>
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<td>27.9</td>
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<td>43</td>
</tr>
<tr>
<td>14</td>
<td>Lethbridge Park</td>
<td>35.2</td>
<td>18.2</td>
<td>18.2</td>
<td>41.1</td>
<td>33.2</td>
<td>2.9</td>
<td>30</td>
</tr>
<tr>
<td>15</td>
<td>Tregear</td>
<td>34.2</td>
<td>38.0</td>
<td>16.8</td>
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<td>25.3</td>
<td>3.1</td>
<td>28</td>
</tr>
<tr>
<td>16</td>
<td>Cabramatta</td>
<td>33.9</td>
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<td>3.0</td>
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</tr>
<tr>
<td>17</td>
<td>Busby</td>
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<td>18</td>
<td>Whalan</td>
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<td>32.7</td>
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<td>Carramar</td>
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<td>24.2</td>
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<td>South Coogee</td>
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<td>Malabar</td>
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<td>Canley Vale</td>
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<td>15.0</td>
<td>8.0</td>
<td>18.0</td>
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<td>20.1</td>
<td>3.1</td>
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<tr>
<td>40</td>
<td>St Marys</td>
<td>28.6</td>
<td>24.5</td>
<td>10.2</td>
<td>9.4</td>
<td>20.7</td>
<td>2.5</td>
<td>35</td>
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6.4.5 Discussion of the study results

6.4.5.1 Observations

The study shows that only a small proportion of very low income households (income<$400) in Sydney are located in suburbs with a concentration equal to or exceeding 40%; 7 out of the 461 suburbs included in the study are in this category, or 2% of the total of very low income households in Sydney.

As would be expected, the proportion of suburbs and proportion of residents increases with categories involving higher income thresholds and lower concentrations of similar incomes; for example, 42% of Sydney’s poor and vulnerable households (income <$600) are located in 126 suburbs, given a concentration threshold of 33%.

The expected relationship between sole parenthood and low income suburbs was also observed, as was that between unemployment rates and low income suburbs, with both those factors highly correlated with low incomes suburbs.

Examining Sydney’s 40 poorest suburbs (ranked by percentage of very low income households [$<400]) shows that most of these suburbs are highly disadvantaged on a range of measures when compared to the Sydney average. Although it should be noted that there are variances in average household size between suburbs – so that in relative terms, those with higher average household sizes are worse off.
There are generally:

- high concentrations of sole parent families (average 35.5%, Sydney average 15%)
- high unemployment rates (average 13.8%, Sydney average 6.6%)
- high rates of car-less households (average 26.6%, Sydney average 14%), and
- a high percentage of public housing (average 32.55%, Sydney average 6%).

The very poorest suburbs have very high rates of public housing, with the ten poorest suburbs having densities ranging between 31.6% and 91.7%.

It might be expected that low income concentrations in other Australian cities would be lower than those observed for Sydney, given the cost of housing in Sydney and the higher levels of public housing than in other states. However, this can only be determined with certainty by undertaking a similar analysis for these other cities.

6.4.5.2 Interpretation

This data reveals a number of issues relevant to this thesis. First, if there were an approach which targeted disadvantaged suburbs in Sydney in an attempt to reduce health disadvantage, this would indeed 'miss more people than it included' (the criticism that has been made of locational approaches – see Chapter 5 and onwards). In particular, if only the suburbs with a relatively high concentration of very low income households were targeted, only a small minority of health disadvantaged people living in Sydney would be reached. Expanding the definition of what constitutes a 'disadvantaged suburb' would

naturally increase the number of potentially health disadvantaged people contained in such suburbs, and include a greater proportion of suburbs with larger average household sizes (which are therefore relatively worse off given the same average income). However, a hypothetical approach targeting these suburbs would still reach less than half (42%) of the households earning less than $600 a week.

It is also necessary to note that the last category (household income <$600 at 33% concentration) is probably a generous definition of a disadvantaged location, particularly considering that many of these households may not be considered socio-economically disadvantaged in terms of their disposable income (e.g., people who own their home and have no children). Additionally, a locational approach working from this definition would involve over a quarter of Sydney’s suburbs. This approach might appear logical: if 25% of all people are health disadvantaged, targeting 25% of suburbs is appropriate. However, even if this was to be done, the interventions involved would (at very best) include 42% of the (possibly) health disadvantaged. Defining a disadvantaged location by increasingly generous parameters in order to include more of the health disadvantaged population would not be appropriate, in that more and more suburbs would be included, resembling a generalist rather than locational approach.

The correlation between unemployment and low income suburbs and sole parents and low income does not reveal anything other than to confirm that, given these populations tend to have low incomes, a high concentration will be associated with a large low income population. What is of greater interest is the fact that there is a strong relationship between unemployment and sole parenthood. At one level, this would be expected given housing costs and the eligibility for public housing brought about by being a welfare recipient; it also

would support the supposition that these two variables may be associated. A correlation analysis cannot reveal this relationship, but the fact that high rates of sole parenthood and unemployment co-exist suggests that the reasons for this convergence need to be explored, and also that interventions designed to support these populations are definitely worth investigating.

The strong relationship between very low income concentrations, other measures of socio-economic disadvantage and high densities of public housing supports the proposition that public housing artificially concentrates socio-economic disadvantage in particular suburbs. This means that if a locational approach to address health disadvantage were to select locations on a 'priority basis', the suburbs involved would always be those with high density public housing. The full implications of this conclusion are discussed in the next section.

### 6.5 Conclusions

In Australia, there is a clear and growing locational dimension to social exclusion and hence the socio-economic determinants of health disadvantage. However, income segregation is partial, and contextual factors derived from location itself, whilst having an important role in affecting the socio-economic determinants of health, are still less important than individual factors (pertaining to individuals). This section examines the implications of these observations for a locational approach to address health disadvantage. A number of conclusions can be drawn from the issues analysed and discussed in this chapter:

- Each Australian city has locations in which socio-economic disadvantage and the socio-economic determinants of health are concentrated.

- In Sydney, most lower income households are not in suburbs where most other people are also receiving lower incomes (and residential heterogeneity is likely to be greater in capital cities with lower housing costs).

- The highest concentrations of low income households are in areas of public housing. The vast majority of low income suburbs have higher than average concentrations of public housing within them.

- There is a correlation between unemployment and sole parenthood at a suburban level, and there is some suggestion that these states may be causally related.

- There is emerging evidence to show that contextual effects have a corollary with the socio-economic determinants of health disadvantage; for example, unemployment and sole parenthood.

- There is a clear indication that some disadvantaged locations are also locationally disadvantaged; for example, in relation to employment opportunities or transport.

These conclusions have a number of implications for the potential of locational approach to addressing health disadvantage. The spatial segregation of socio-economically disadvantaged populations in Australian cities is comparatively minor when compared to some cities in Europe and the US. Despite an increasing tendency towards concentrated disadvantage, the large majority of the lowest income households are not located in suburbs where the majority of other households are also earning low incomes. Although, from a social justice perspective, economic diversity is probably desirable, this situation does suggest a limitation to a locational approach if low income earners (hence by
inference socio-economically and health disadvantaged people) are spread through large numbers of suburbs, rather than being concentrated in ghettoes. Therefore, in the Australian context, a very important limitation of a locational approach aimed at the most disadvantaged suburbs is that only a minority of the health disadvantaged population will benefit.

Public housing also plays an important role in concentrating disadvantage, which has a range of implications for intervention efforts. First, most poor suburbs have greater than average concentrations of public housing, with the very poorest having substantial proportions of those suburbs’ households occupied by public housing tenants. Furthermore, a number of those suburbs are clustered together, clusters essentially comprised of large public housing estates, such as those at Mt Druitt and Liverpool in NSW. This clustering pattern means that any approach to alleviate socio-economic and or health disadvantage centred on the most disadvantaged locations will inevitably end up focusing on these estates. In some respects, this approach may be warranted: for instance, when concentrated public housing is also accompanied by locational disadvantage and negative ‘contextual effects’. The evidence also suggests that proportionately more health and social services should be provided to respond to a higher demand. However, focusing on public housing estates also has a number of critical problems.

It is clear from the discussion above that public housing in Australia has been transformed into welfare housing, where few tenants are employed. Efforts to promote employment for potentially employable tenants face a dual challenge: tenants who move into full time employment experience a substantial loss of welfare benefits and a probable loss of public housing tenancy. For those able to break fully from welfare dependency, rising rents (paid in proportion to income) mean a strong incentive to leave public housing and, quite possibly, the
location as well. In this sense, the socio-economically disadvantaged profile of concentrations of public housing can never change to any great degree, regardless of how good interventions might be: shifting people into jobs shifts them out of public housing, with new welfare dependent tenants moving in to replace them.

Of course, large proportions of public housing tenants are not in the employment market at all, being retired, sole parents, sick or disabled; alternatively, even if they are nominally 'job seekers', they may never in reality become employed. Accordingly, measures to improve the well being of these populations are certainly justified.

Another potential problem with focusing interventions primarily on public housing estates would be the tendency to see the most visibly disadvantaged households concentrated in these locations as more in need of assistance than those dispersed through other locations. There are many thousands of people on public housing waiting lists and many more low income private renters experiencing housing stress. In this sense, residence in public housing *per se* is an inadequate measure of the extent of need in a city. Furthermore, the advantage that public housing tenants have of secure affordable housing could conceivably outweigh the disadvantages associated with living in large scale public housing (e.g. suburb stigma and other locational disadvantages).

The tendency of sole parenthood and unemployment to become both highly concentrated and co-concentrated in low income suburbs has a number of implications for a locational approach to address health disadvantage. Exposure to either of these states has independent health risks associated with it, in addition to the health risks associated with socio-economic disadvantage. These health risks would suggest that any location with a high number of unemployed

people or sole parents would require extra health services to meet the needs of these populations.

Preventing the creation of sole parent families and unemployment in the first place is a much more challenging matter. It would appear that these states could be influenced by identifiable contextual factors at a locational level; for example, relating to quality of schooling and job opportunities. There is also the suggestion that they are related to one another, with sole parenthood rates rising with the unemployment rate. At this stage, it is too early to determine all the factors involved: however, it does suggests that there could be some scope to begin addressing these issues with a locational approach.

Locational disadvantage is also clearly an issue, and there is evidence that people in disadvantaged locations face additional barriers to their full social and economic participation. In particular, factors such as inadequate employment opportunities, poorer quality schooling and inadequate transport and facilities, limit people’s opportunities. The impact on health disadvantage of the factors comprising locational disadvantage has yet to be determined. They are, however, clearly influential on the socio-economic determinants of health. In addition, they are factors that can, at least to some extent, be addressed with locational interventions; for instance, interventions could include improving transport links to outer suburban areas, increasing funding to schools in poorer areas and job creation schemes.

Clearly, there are a number of immensely difficult issues with which to grapple. The next chapter explores some of the attempted solutions to these issues – having identified the problems, can they in fact be addressed?
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

7.1 Introduction

It is apparent that taking a locational approach to reduce health disadvantage is likely to have substantial limitations. The thesis to this point has found that such an approach cannot address the fundamental causes of health disadvantage, will have a limited population reach and cannot be justified by the contextual effects of location on health. The focus of this chapter is what, given these limitations, a locational approach can reasonably be expected to achieve.

In practice, a locational approach has been used by governments to specifically address health disadvantage. Locational approaches have also been used in attempts to address the socio-economic determinants of health, including poverty, unemployment, educational disadvantage and urban decay. However, the mere existence of such approaches does not mean they are effective.

If the case can be made for even limited effectiveness of a locational approach to reduce health disadvantage and/or its determinants, then, so too can the case be made for using a locational approach. That is, even a policy approach of limited effectiveness can be seen as favourable to no policy, provided it provides some benefit to health. Disadvantaged locations clearly do attract government social spending, even from those governments incapable or disinterested in addressing the wider causes of inequality. In this sense it provides an opportunity for money to be directed at alleviating health disadvantage – however, the question of effectiveness – actual and potential – remains paramount.
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

So, within this increasingly narrow range of possibilities there exists the potential for a locational approach to:

- moderate the effects of socio-economic disadvantage on health (e.g. through providing extra health services or early intervention programs), and/or
- address some of the factors which create and perpetuate social exclusion (including unemployment, social isolation and difficulties in early life).

This chapter considers the potential of location based policies and interventions in general. In the second part of the chapter, four location based policies (and their accompanying interventions) are discussed. These are:

- health equity spending (allocating more health resources)
- early intervention (support for young children and families)
- social mix (changing the income mix of households in a location), and
- social capital creation (building community links and cohesion).

With the exception of social mix, all four policies have been implemented (or advocated) with the intention that at least some health improvement will result, even if that is not the primary motivation. Social mix was selected for consideration because of the claims made by its supporters that it can alleviate many of the problems associated with disadvantaged locations.
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

Of these four policies, early intervention is the only policy that has been extensively, and long term evaluated, the discussion therefore focuses on:

- examining the rationale for the policies
- discussion of the possible non-health outcomes of the policies
- whether or not the policies are justified given the evidence base concerning the causes of health disadvantage, and
- if the locational application of these policies is justified.

7.2 A locational approach to disadvantage: brief overview

In Western Europe, since the 1980s there has been a distinct policy shift in social and urban policy to include locationally targeted approaches.[40, 432] Individual countries and the European Union have sought to supplement generalist policies with policies aimed at specific locations.[433] This policy shift has been explained as a response to a number of factors, including the burgeoning costs and apparent poor returns of across the board welfare spending[261] and growing concern about the increasing spatial polarisation of cities associated with areas of very high unemployment, ethnic ghettos and urban decay. Problems of inequality, unemployment and poverty have, to an extent, come to be seen as problems delineated by location. Within the European Union locational policies are a key focus, many at a scale far larger than has ever been pursued in Australia, with policies aiming to ensure that large cities and complex industrial regions remain economically competitive.[434]

Of the Western European nations, the United Kingdom has been at the forefront of developing locational polices.[435] These policies, developed since the late
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

1990s, form a central part of New Labour’s efforts to ameliorate social exclusion. The policies include Action Zones for health, employment and education, the Sure Start early intervention program and the New Deal for Communities.[436] Like Australia, there has also been a focus on ‘problem’ public housing estates, albeit from a national level and involving much larger estates and many more households. Neighbourhood renewal programs have attempted to address problems seen as characterising these estates, such as drugs, crime, unemployment, teenage pregnancy, community breakdown and poorly performing schools.[253, 437]

In the US, there has been a long history of locational policies in urban areas, beginning at around the end of the 19th century.[430] According to Modarres, these policies were originally a response to the demands of progressives that governments intervene to address urban poverty and cure some of the problems which they believed were caused by uncontrolled capitalism.[38] Subsequently, there has been heavy federal involvement in urban areas of growing cities, particularly in the era of the New Deal and in the 1960s ‘war on poverty’. [317] This locational level involvement has continued to the present day, with anti-poverty programs being funded in cities throughout the US.[37, 438]

In Australia, under its current government, promoting equity across the geography of cities is not a policy concern and federally initiated locational policies are essentially non-existent. Indeed, historically, locationally targeted policies have not featured prominently as part of the Australian federal political landscape.[409] The only federal government to seriously pursue locational policy was the Whitlam Labor government of the 1970s: in conjunction with sweeping welfare reforms and universalist equity policies, a wide range of initiatives in disadvantaged locations were implemented.[43, 293] In more
recent years, with the exception of the modestly funded 'Better Cities Program' under the Hawke Labor government,[431] locational policy, such as it is, has been almost entirely generated by state and local governments.[43] These policies have included the renewal of public housing estates, the 'breaking up' of these housing estates, and a large variety of smaller interventions in disadvantaged locations (see below and Chapter 8).

When it comes to health policy, the Australian approach has been overwhelmingly universalist rather than locationally targeted. Similarly, within public health itself, population targeted policies such as immunisation and screening have tended to dominate.[439] However, and although they are sparsely funded and not systematically evaluated, there are many small locationally targeted interventions designed to promote better health in Australia. Examples of these are discussed in the next chapter, and, whilst they are locational based, these interventions do not reflect a co-ordinated locational approach to the problem of health disadvantage, as seen in the UK for example.

7.3 Rationale for locational approach

There is clearly a belief that a locational approach is an effective way of addressing various urban, socio-economic and health problems. That is, the endurance and growing popularity of this approach suggests that there are sound reasons for choosing location as an intervention level and/or using interventions at this level as an adjunct to universalist policies. The rationale and asserted benefits of a locational approach are discussed in this section.

In theory, there are a number of reasons for pursuing a locational approach to address the various elements of social exclusion and socio-economic disadvantage. Smith explains that a locational approach is justified if
disadvantage is concentrated in identifiable locations, and there is evidence that location related factors could at least partially explain this disadvantage.[435] Thus, for instance, a locational approach could be justified in the UK, as some locations clearly suffer disproportionately from problems such as unemployment and issues of multiple deprivation, including health problems, lack of school achievement, crime and drugs. In particular there are also a range of location related factors which appear to impede employment opportunity. Smith identifies the following issues: the reluctance of employers to locate businesses in disadvantaged locations, skill mismatch between local populations and available work, postcode discrimination, transport difficulties in peripheral locations and a lack of social networks to link people to jobs.[435]

It also makes sense to address issues locationally if they are clearly confined to this level; for example, issues of housing quality, the physical environment and local service delivery.[436] In Australia, this type of activity is in evidence with urban renewal programs in which public housing is reconfigured and housing stock renovated.[44, 48] In respect of these types of physical interventions, visible results can potentially be produced in a short space of time.

Identifying problems as locationally based is a major of the rationale for a locational approach. Another justification is that working at a locational level is likely to contribute to the effectiveness of interventions; that is, the argument that an intervention is more likely to produce desired outcomes if delivered locationally. For example, working at this level is seen to enhance cooperation between agencies through creating a common focus for activity[41] (in particular for government departments, who may lack structures for co-operative activity).[435] A locational basis is also seen as enabling local participation in problem resolution by the people who are actually affected by
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

that problem.[41, 435] Andersen and Van Kempen state that this intervention level can generate considerable 'synergy': "combining the involvement and cooperation of the local community with various public authorities, businesses and other organizations."[41]p.82.

However, even those supportive of locational based policies and interventions recognise their limitations and understand that they must be linked to 'people based policies'.[41, 303, 435] Madanipour and colleagues observe that:

physical improvements of housing and living environments do not, in themselves, address the wider social problems experienced by residents... thus, initiatives which do not connect with these wider processes to find local solutions are likely to be ineffective and short lived.[39]

Other advocates of a locational approach have also noted limitations, for example, that most of the unemployed in a nation will not be reached, that very small area targeting will only cover a fraction of the unemployed and that some issues can only be addressed at the national level or, indeed, the international level.[435] There is a view that policy makers need to be realistic about what a locational approach can achieve, especially given the time limits and extensive range of problems at which they have been directed.[303]

When it comes to addressing health disadvantage directly, supporters of a locational approach argue that it is justified due to the locational dimension to health inequalities, the contextual effects of location on health and the fact that it enables community involvement in addressing health issues.[341, 440] It has also been stated that a sizable evidence base exists concerning effective locational approaches.[341] However, this assertion has been contradicted by researchers at the South Australian Community Health Research Unit, who state that the evidence base for health related locational interventions is 'generally
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

considered to be quantitatively small and qualitatively poor', but who do go on to claim that these deficiencies are most likely due to methodological problems rather than the 'lack of effectiveness of locational interventions'.[440]

7.4 Critique of a locational approach

Contrasting the restrained support for a locational approach to addressing socioeconomic disadvantage has been the vehement critique from a range of European and US theorists.[37, 38, 432, 436, 441, 442] These theorists point to the historic failures and limited population reach of locational interventions and the fundamental inability of a locational approach to address social exclusion and the problems inherent to capitalist economic systems.

Taking a pragmatic view, perhaps the most telling critique of a locational approach is the repeated failures of these efforts to ensure lasting change of the economic and social fortunes of the people at whom and locations at which they are directed. Oatley points to four decades of research that question the ability of locational policies to address the 'paradox of poverty': the continuing growth of poor populations in an affluent world.[38]

In the US, Modarres argues that despite years of locational based poverty alleviation policies, the problem has remained constant, and even worsened in some places; for instance, in Los Angeles county a program called the 'Supplemental Empowerment Zone' was applied, and after a decade involving millions in spending the county poverty rate had increased from 15.1% to 17.9%.[38]
Taylor and Jones question the ability of rafts of small disconnected initiatives to challenge structural racism and social class inequalities, arguing that:

few initiatives have fundamentally transformed neighbourhoods or changed the trajectory of older inner city places...the various... enterprise zones, community development corporations, community economic development, community building, social capital initiatives, community policing, university-community partnerships, faith-based initiatives, and most recently comprehensive community initiatives have amounted to less than the sum of their parts.[320]p.4.

Similarly, in the UK, years of urban and regional policy interventions "have not changed the basic map of uneven development."[441]p.107. After four decades of interventions the locations that were poor once are still poor today. Fordham points out that many of the neighbourhoods targeted for interventions under the current national program are exactly the same as those targeted during previous rounds of locational interventions: "which hardly amounts to a ringing endorsement of these earlier initiatives."[443]p.3.

Jones and Ward assert that in the UK the problems of uneven development have actually been exacerbated by locational interventions and that a cycle has developed where the various attempted 'fixes' of one government create further unanticipated problems that subsequent governments will then attempt to solve;[442] for example, they point to the various conflicting state efforts to configure 'partnerships' at local level and the problems of forcing disadvantaged regions to compete with one another for resources and funding.

Often the problem of disadvantaged locations is seen as a lack of connection with other locations and the economy, so that the location is viewed as being isolated from opportunity.[441] However, Chatterton makes the argument that the problem is that disadvantaged locations are connected with the wider economy[441] but are far more susceptible to periodic crises (recessions) and
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

Increases in unemployment. This was illustrated in Chapter 6, where it was shown that unemployment in disadvantaged locations increases disproportionately during recession. On the other hand, the development of local employment programs cannot necessarily be limited to local populations: employment strategies and private sector development in disadvantaged locations may largely attract people from outside the area.[320, 441]

There is also a related argument that so called 'spatial fixes' are not capable of resolving the problems caused by capitalism economic systems and neo-liberal governments.[442] From a Marxist perspective, the capitalist economic system is bound by its own internal logic to experience periodic crises in which profits fall and recession ensues. These recessions do not affect populations evenly across locations but impact more adversely on those employed in particular industries and those who are already poor and vulnerable;[246] for example, unemployment can come to be heavily localised because manufacturing industries are also localised. The next recession can be expected to have a greater impact on those who are insecurely employed and who tend to be concentrated in particular locations.

It could be argued that rebuilding industries in depressed locations could answer the problem of localised unemployment (indeed promises of this nature are often the government response to rust belt locations). However, given the constant cycles of boom and recession and the large body of permanently insecure workers, new industries can at best displace the next crisis to a different location.
For Marxist geographer Harvey, uneven development is inevitable under capitalism: "the inner contradictions of capitalism are expressed through a relentless formation and re-formation of geographical landscapes. This is the tune to which the historical geography of capitalism must dance without cease." (Harvey in [442]p.2.)

Despite the apparent futility of using locational interventions to permanently fix the contradictions of uneven capitalist development, location continues to be the primary site where governments attempt to resolve problems of social exclusion and socio-economic disadvantage (such as unemployment and concentrated disadvantage). This behaviour could be interpreted in two ways; either as an obfuscation of what actions are really necessary to address these problems, or politically expediency. In the first case, a preference for locational policy could be viewed as a deliberate obfuscation of the real causes of social exclusion and socio-economic disadvantage in a society (recalling that Shaw and colleagues made a similar argument in regard to health disadvantage – see Chapter 3). That is, the approach leads social exclusion and socio-economic disadvantage to become associated with location rather than the economic processes of capitalism: "when areas are seen as pathological there is a strong temptation for capital causation to be inferred from the spatial incidence of social and economic problems."[436]p.89. In the case of political expediency, the view could be taken that governments in capitalist democracies are not complete puppets of capitalist interest but must also appease other groups to ensure continuing re-election.[444] Thus, governments are compelled to intervene to attempt to resolve problems to ensure their own survival; spending money in disadvantaged locations may have little hope of resolving the deeper causes of
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

social exclusion and socio-economic disadvantage, but it does give the appearance of 'doing something'.

7.5 Specific locational policies

From the above discussion it may appear that a locational approach to the socio-economic determinants of health disadvantage does not have a great deal to recommend it. There are both intrinsic limitations and a poor track record in relation to addressing the big issues of poverty and unemployment. However, this does not mean that locational policies are necessarily without merit, just that what they can achieve is by necessity fairly small scale and confined to a limited population group. Four locational policies and their associated interventions are now examined.

7.5.1 Health equity spending

In Chapter 2, it was observed that health inequalities researchers have tended to be dismissive of the contribution of health services to the health gap between rich and poor (e.g. see [26]). This follows in part from the apparent minimal contribution made by medical care to advances in population health and also because in most affluent countries, including Australia (outside rural areas), there do not appear to be marked socio-economic differences in access to primary health care. Additionally, all families in Australia on an income under $30,000 a year are eligible for a Health Care card, ensuring no cost GP consultations and low cost pharmaceuticals.[427] These observations would appear to imply that reducing the health gap, at least in Australia, is not a question of providing more medical health services to socio-economically disadvantaged people.
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

However, there is evidence that the relationship of health services to health disadvantage may be more complex than this analysis (above) suggests. Although research is minimal in this area, it has been found that differences in quality of health care do have a potentially buffering effect on health disadvantage (see Chapter 2). Also, there is evidence to suggest that tertiary and secondary care access does differ by income group.[445] For example, in some Australian cities the health workforce is maldistributed between inner and outer urban areas.[Australian Government Productivity Commission, 2005 #709]

Proportionately lower numbers of GPs have apparently led to an increase demand on hospital casualty services[446] and would suggest that patients receive less time and service from individual GPs, for example, a Perth study found spatial inequities in out of hours provision, consultation times and service on short notice.[448]

Even though knowledge is limited about the effectiveness of health care in alleviating health disadvantage, there still needs to be some basis which guides the allocation of health resources. According to the principle of ‘vertical equity’, socio-economically disadvantaged people should be allocated more health services because of the greater burden of ill health they suffer.[447] Mooney and Wiseman also argue, in relation to spending on indigenous health, that these decisions should involve the principle of ‘procedural justice’; that is, not only should there be a greater response to need but that also health gains should be weighted differently for different recipients of the gains.[125, 449] In essence, this means that gains in indigenous health can actually be valued more highly than health gains by more advantaged population groups.

The principle of procedural justice could also be applied to health disadvantage;[450] that is, not only should more health resources be allocated to
socio-economically disadvantaged people, given their greater health needs, but also that more should be spent pursuing gains in the health of socio-economically disadvantaged people because health gains for this group are more valuable than health gains for other socio-economic groups (e.g. middle income earners). Of course, this opens a whole other area of inquiry, but it could be argued that as socio-economically disadvantaged people (including indigenous people) suffer a greater health disadvantage than all other Australians, improvements in their health outcomes are of greater value in equity terms because of this initial disadvantage.

The question then arises of how this thinking might apply at a locational level. There are a number of potential locational dimensions to the issue of health care service provision. People need services that they can physically access, preferably within reasonable travel distances from their homes, particularly in outer suburban areas with poor transport and low car ownership rates. Hyndman argues that it would be logical to place more GPs in deprived areas 'given that demand for primary medical services is directly related to social disadvantage'.

There is clearly a case, therefore, to place proportionately more health services in disadvantaged locations; for instance, by using the socio-economic profile of locations to model health needs and then to allocate health spending on that basis. However, the extent to which this can assist with addressing health disadvantage is dependent both on the proportion of the population this would reach and the effectiveness of these services. With the former, it is apparent that only a limited proportion of the health disadvantaged will benefit, whilst on the latter point there is still insufficient evidence to make any sort of definitive
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

claims as to the extent of health improvement that could result. All told, it is certainly an area for which there is a compelling need for more research.

7.5.2 Early intervention

The importance of early life in the trajectory of developing health disadvantage was discussed in Chapter 2. It was shown that psychosocial and material adversities during the early stages of life confer a significant disadvantage for later health. Early life risk is patterned by income and socio-economically disadvantaged children face the double jeopardy of being both more likely to be exposed to risk factors and an increased likelihood of suffering adversely from their exposure[145] In addition, growing up in a low income family increases a person's chances of becoming a low income adult, which in turn carries further risks for health.

For these types of reasons interventions aimed at socio-economically disadvantaged children and their families have strong support amongst public health researchers and professionals[200, 206] and also among those interested in addressing a wide variety of social problems (which are also determinants of health).[264, 451] Early intervention programs are typically promoted as public policy investments with high returns in terms of child development, crime prevention, and improved academic, employment and economic outcomes.[240, 452] In particular, early intervention is viewed as capable of reducing the impact of poverty on developing children, for instance:

Mission Australia is convinced that the development of adequate early intervention and prevention strategies available at the known steps of social and economic disadvantage and at significant life transition points would significantly reduce the impact of poverty for many Australians.[264] p.153.
Patently, if effective, intervening earlier rather than later could prevent a wide range of problems before they begin. Frequently, too, early intervention policies are delivered on a locational basis through families, schools and early childhood services in disadvantaged locations.

When it comes to developing early interventions to reduce health disadvantage, it appears that the pertinent issue is the social determinants of health rather than health disadvantage specifically. Hertzman and Wiens express the view: "if childhood interventions were to improve health and well-being throughout the life-cycle and address the socioeconomic gradient in health status – they would be more likely to be social or educational interventions than health interventions per se."[196] p.1088. That is, these authors take the same perspective as that taken in this research: namely, that addressing health disadvantage is more about addressing lifetime socio-economic disadvantage than focusing on specific health problems at isolated stages in the life course (see Chapters 1 and 2). Thus, in considering whether early intervention might assist health, Hertzman and Wiens focus on social and educational interventions – this approach is also taken in this section.

Unlike the other policies and interventions considered in this chapter, early intervention has been extensively evaluated. The US is at the forefront of early intervention and large scale early intervention programs aimed at socially excluded children and families have been operating there for decades.[196] Evaluations involving the children and families who have participated in these programs provide a rich source of data about the outcomes that early intervention can achieve; although, as yet, there are limited longitudinal studies.[28] However, as has been emphasised earlier in this thesis, poverty in Australia and the US are very different and this needs to be taken into account.
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

when considering the possibilities of early intervention in this country. Having said this, it is not unusual for Australian advocates of early intervention to cite the American experience (see for example [175]).

Perhaps the best known early intervention program is the Head Start program in the US; started in 1965, it has involved more than 20 million children, with a $6 billion dollar budget.[28] Other smaller US programs have included the:

- Perry Preschool Project
- Comprehensive Child Development Program (CCDP)
- Infant Health and Development Program (IHDP)
- Chicago Longitudinal Study, and
- Abecedarian Program.

Most programs have focused on educational outcomes and increasing cognitive capacity (as measured by intelligence quotient[IQ]).[28]

If programs such as these are effective, health benefits could be expected to follow. That is, improved educational outcomes could be expected to benefit health by leading to lower rates of unemployment, increased income over a lifetime and a reduction in the adversities associated with socio-economic disadvantage (such as involvement in crime, or teenage pregnancy).

A number of conclusions can be drawn from examining the review literature and discussions of these early intervention programs.[28, 145, 453-457] These interventions can, without question, create positive effects, in particular: increased IQ, improvements in school readiness and reductions in grade repetition. Also, in regard to the long term social cost savings (relating to factors
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

such as early school leaving, imprisonment and divorce) these programs can be impressive (particularly the Perry Preschool Project). However, on the whole, improvements are fairly modest in comparison to control groups. In terms of increasing IQ, there is little evidence that this advantage can be sustained once children leave these programs. Improvements are also mostly in relation to other socio-economically disadvantaged children rather than bringing participants on par with children of wealthier parents; for example in the Abecedarian Program, although the students involved did have IQ gains they were still on average 20 IQ points less than their classmates at the completion of the program.[145]

Despite the limitations on improving cognitive and school performance outcomes, other long-term social and behavioural benefits have been observed for participants in early intervention, although it is important to note that these benefits are mostly associated with intense, expensive, model programs.[145] One of the best known interventions of this type is the Perry Preschool Project, which involved providing high quality pre-schooling for disadvantaged children, with low staff to student ratios and home visiting to engage parents in their children's schooling.[458] This project clearly did 'work': follow ups at 27 years found reductions in the expected rates of criminal activity, welfare dependence, school drop out, out of wedlock childbearing and drug abuse.[456, 458] The cost-effectiveness of Perry has been determined as $US7.16 saved for each dollar spent.[456] Smaller positive results on educational outcomes were also found for four other early intervention programs.[456]

Clearly, reductions in these negative outcomes might be expected to have additional health benefits, although here, too, it is well to be mindful that the children, while experiencing remarkable improvements compared to the control
groups, "would not nearly match those of middle class children who had greater opportunities but no special preschool experience."[196]p.1087.

Another popular approach to early intervention involves home visiting of socio-economically disadvantaged families by professionals (e.g. nurses) or trained lay people who offer a range of services including information, support in developing parenting skills and companionship. The outcomes commonly expected from home visiting include: improved child health, improvements in cognitive development, improved relationships, improved maternal outcomes, reductions in child abuse and neglect, reductions in injury rates.[459] These programs are growing in popularity in Australia (see for instance Families First in NSW[460]) and are widespread in the UK and the US.[459]

Despite the popularity of home visiting and the expectation that it is a cost effective way of improving life chances for socio-economically disadvantaged children, the results of evaluations have also been largely disappointing. In summarising the evaluations for six large scale home visiting programs in the US, Gomby and colleagues made this comment: "When program benefits were demonstrated, they usually accrued only to a subset of the families originally enrolled in the programs, they rarely occurred for all of a program’s goals, and the benefits were often quite modest in magnitude."[459]p.6. Similarly, a meta-analysis of sixty home visiting projects found that improvements were often negligible and mostly less than twenty percent on baseline.[461]

Studies of programs providing case management and support for the whole family of disadvantaged children have revealed even less promising results than other types of early intervention; for instance, The Comprehensive Child Development Program (CCDP), a US$326 million demonstration experiment at twenty one sites involving community based comprehensive, case managed
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

support for socially excluded families with children, evaluations found no effects on parental or child well being when compared to control groups.[454, 455]. Similarly ineffective were two other programs targeting 'the whole family', leading to the conclusion that "comprehensive, case managed, two-generation programs do not produce substantial benefits in either parents or children."[455] (It is also interesting to note that the authors coming to these conclusions were actually supporters of the programs – and deeply disappointed by the results.)

The conclusion to be drawn from these US examples is that early intervention can make a difference to the outcomes for socio-economically disadvantaged children, but that good results (in comparison to other poor children) have mainly been the product of expensive intense efforts involving fairly small numbers of children. Thus it is not appropriate to take the outcomes of these programs, which probably represent the maximum benefit of early intervention,[145] to justify quite different programs. For instance, the Families First Initiative in NSW cites the Perry program as a reason for early intervention,[240] yet the interventions comprising Family’s First initiative are of a far more limited intensity. Even those generally supportive of early intervention are cautious in their support when confronted with the outcomes of this policy emphasis; it is still a judgement call as to whether the outcomes of these programs justify a major policy initiative.[456]

There are other problems, too, when drawing from the US examples to inform Australian practice. It is necessary to note that educational and health outcomes for children in the US are worse than in Australia, so the degree of benefit may be 'attenuated in the less-extreme Australian context.'[175] This is not to say that early intervention should be abandoned as worthless, but it does need to be emphasised that it is not a 'magic bullet'; compensatory efforts aimed at this part
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

of the life course will have at best a modest impact on educational and social outcomes and, if they are to be effective, interventions will probably be high intensity, of long duration and expensive.

Furthermore, it may well be that too much is being expected of these interventions, given they are largely targeted just at children rather than the whole family and delivered over relatively short time scales. The children targeted by these interventions are, by and large, living in families in which the disadvantage is entrenched and multigenerational – that is, their parents or carers are usually experiencing socioeconomic and other substantial disadvantages (e.g. sole parenthood, unemployment substance abuse etc) and most likely grew up in disadvantaged families themselves. Thus, in order to see the full impact of which early intervention is capable, the scope and time scale of these programs may need to be considerably increased; providing, for instance, high level assistance for both parents and children over a long period of time, or indeed over several generations.

In practice, early intervention programs are often delivered on a locational basis, with children living in identifiably disadvantaged locations being the focus of intervention activities. Given the modest impact of many of these programs as they are currently delivered, whether they are delivered spatially or on a more general basis is perhaps of little consequence to outcomes. This issue aside, a locational approach has some benefits. Logistically, it is easier to operate a program with a larger number of children in limited locations than with a small number of children across all locations; for instance, using the local preschool or school to run the programs. Of course the limitations to a locational approach are also present; namely, most of or a large minority of socio-economically disadvantaged children will miss out on the interventions. This issue leads
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

Alperstein and Nossar, in their assessment of the likely impact on health inequalities of the NSW Families First early intervention program, to question the value of targeting geographically disadvantaged locations.[175]

7.5.3 Social mix

Social mix is the policy of changing the income mix of a disadvantaged location or establishing a new residential area, using mechanisms to ensure the inclusion of a range of low and higher income households. This policy has been extensively implemented in the US and the UK, where the creation of income mixed and balanced communities are seen as a means to reduce social exclusion and solve the problems associated with concentrated socio-economic disadvantage; for instance, the exclusion of people from employment networks, locational stigma and the normalisation of anti-social behaviour.[462, 463] Similarly, in Australia, interventions that attempt to increase the social mix have been applied with the intent of resolving some of the entrenched problems associated with large public housing estates.[49, 464]

Social mix is an interesting issue to consider in terms of health disadvantage; although better health is not a stated outcome of the process, its intended outcomes are clearly directed at improving the socio-economic determinants of health, for example, employment opportunity and increases in social capital: Cave and colleagues cite social mix measures in their review of evidence of the health impact for regeneration projects[465]). Also, clearly, increasing the social mix of an area will automatically reduce compositional effects on health disadvantage (assuming that higher income residents maintain their income level). The real question, of course, is whether socio-economically disadvantaged people are likely to benefit from having neighbours with higher incomes.
Theoretically, social mix appears to offer a number of potential benefits. These are summarised by Randolph:

- promotion of greater social interaction and social cohesion
- better community 'balance'
- encouragement of mainstream norms and values
- creation of social capital
- overcoming place-based stigma
- sustainability of renewal/regeneration initiatives, and
- improved non-shelter outcomes:
  - opening up of job opportunities
  - attracting additional services to the neighbourhood
  - reduced crime and anti-social behaviour
  - improved educational opportunities[49]p.4.

If successful, these types of outcomes would be well worth pursuing in terms of addressing the underlying causes of health disadvantage. The evidence from Australia, the UK and the US shows that some of these outcomes can be achieved by social mix.

Randolph argues that the main rationale behind pursing social mix in Australian public housing estates is asset management concerns: selling off parts of public housing estates is more about funding housing stock renewal and reducing the provision of public housing than any alleged benefits for
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

tenants. Even so, he notes that there has been a major positive outcome for
 tenants of living in a 'less stigmatised environment'.[49] It would seem difficult
to ascertain any measurable health outcomes from reduced stigma, but it is
completely conceivable that this negative psychological state could form part of
a psychosocial burden to health – thus, removing is likely to be positive.

It also seems probable that educational benefits could accrue from having
greater mix of incomes in school feeder population. That is, it could be expected
to alleviate some of the burden of welfare issues on schools catering for
disadvantaged populations (see Chapter 6). It would also be a means of
achieving socio-economic integration without physically transporting students
(a current trend in the US, similar to racial integration measures).

The other alleged benefits of social mix have less certain outcomes.
Improvements in social cohesion and/or social capital are generally not seen to
follow from social mix projects, in that tenants and homeowners tend not to
associate socially.[464, 466, 467] Similarly, increases in employment have not
resulted for unemployed tenants in social mix projects;[466, 468] this is not
surprising, given the lack of social contact between different household types. It
would appear likely that crime could be reduced through increased social mix:
however, results have been mixed on this issue – in some projects crime has
actually increased.[49] Potentially, locational disadvantage (that is, location
specific disadvantage – see Chapter 6) can be reduced through social mix; for
instance, if the locations develop better quality services (e.g. improved transport
and shops), or people are relocated to better serviced areas.

Pursuing social mix could also have unintended negative outcomes; for
instance, the assumption that social cohesion will be improved through social
mix is made in ignorance of evidence that 'strong cohesive communities already
exist on some estates'. These existing communities are effectively destroyed when tenants are dispersed. Another problem which may occur is that diluting disadvantage means that welfare services provided on a threshold basis (i.e. numbers of socio-economically disadvantaged households) may be lost; for example, if extra health services were provided on the basis of socio-economic disadvantage, a justification may be created to remove such extra services if the average household income of an area increases.

The pursuit of social mix (through tenure diversification) also has some logistical implications for a locational approach to addressing health disadvantage. In Chapter 6 it was shown that in Sydney most of the suburbs identified as disadvantaged have higher than average concentrations of public housing. Spreading public housing tenants more evenly through Sydney suburbs will break up these concentrations: a likely consequence would be the elimination of locations which have been an intense focus of interventions and helping efforts. As such, the locational imperative for intervention is lost, or at least diminished, although of course the health and socio-economic disadvantage of the displaced residents will most likely remain unchanged.

In terms of health disadvantage itself, there appears to be little justification for pursuing social mix. The benefits to health are related to how well the socio-economic determinants of health are addressed by social mix – and the impact can be predicted to be minimal at best.

7.5.4 Social capital

Social capital is a strong theme within the health inequalities literature and figures prominently as a proposed solution to ameliorate health disadvantage. Support for notion that building social capital can reduce health disadvantage derives from two theories – that the:
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

- Erosion of social capital has contributed to health inequalities, and
- Generation of social capital is capable of mediating and/or moderating the link between lower income and poorer health [26, 35, 157, 470].

Wilkinson, for example, in the closing chapter for of his seminal work *Unhealthy societies: the afflictions of inequality*, calls for measures to build a more cohesive and trusting society as one of the key ways of addressing health inequalities.[26]

In Chapter 3, it was shown that income redistribution is advocated by psycho-social theorists as a means of restoring collective social capital, with greater income equity being seen by these theorists as associated with more cohesive and trusting societies. Attempting to generate social capital in this fashion would involve policy changes at a national level. Social capital can also potentially be generated through a locational approach and, theoretically, intervening at this level would appear to be particularly suitable for this end. That is, if the aim is to build connections between people, a common location provides a framework to do this, providing, for instance, physical proximity and opportunities for involvement in locality based organisations. Social capital is also understood as being influenced by locational level characteristics,[172] including those of neighbourly relations, amenity provision and physical design and layout. Location thus offers numerous potential avenues for interventions designed to promote social capital.

The generation of social capital at a locational level has attracted interest from researchers concerned with understanding and improving the health of disadvantaged communities.[172, 341, 425] There have also been interventions designed to build social capital in disadvantaged locations, with the direct intention to improve the health of the local residents.[471, 472] Social capital is
viewed as an achievable way of addressing health disadvantage; for example, Baum, a researcher at the forefront of the social capital and health movement in Australia, argues that: "helping people to participate in community life by reducing their fear of strangers and increasing their trust in others is by no means a costly measure, but it is very likely to prove to be a sound investment in both the health of individuals and their communities."[157]p.271.

Social capital has a philosophical appeal to many within public health. It is broadly in line and compatible with ideas within the new public health, primary health care and community health movements of the 70’s, 80’s and 1990s (see for example [157, 473, 474]). That is, notions of the importance of community participation and people dealing with their own problems, integral to earlier projects such as Healthy Cities, are in many respects similar to the concepts within social capital. Thus, although supporters of these earlier movements do not necessarily embrace social capital, those that do will find a certain philosophical consistency.

For all its appeal, the notion of using social capital to promote health within locations has also been subject to fairly intense criticism. At a political level, neo-materialist theorists have argued that it detracts from the need to address the structural determinants of health[74, 475]. At a more pragmatic level, researchers have questioned the efficacy of social capital in reducing health inequalities: "...programmes or policies that encourage the development of individual social capital through involvement in the community may produce benefits to health but they will do little to negate the more fundamental inequalities in health."[159]p.64.

Researchers have also questioned whether social capital can in fact be created[475]. Shortt comments: "despite such enthusiasm […for social
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

capital...] the fundamental question remains unanswered: is social capital both sufficiently well understood and inherently amenable to serve as a policy tool?"[476]p.15.

From the neo-materialist perspective, calls to generate social capital are viewed as part of the reduction of the role of the State in providing social welfare and services. In this view, endorsing social capital provides a convenient way for governments to shift responsibility for problems onto disadvantaged communities, rather than provide the communities with the funds and assistance they need.[74, 475] Also, in terms of understanding causality, neo-materialists object to the positioning of subjective responses to inequality in the causal sequence between socio-economic disadvantage and health disadvantage (a criticism in line with their critique of the whole psychosocial position – outlined in Chapter 3). That is, by seeing the problem as a lack of communities' connections rather than inequality itself, confronting the real problems of socio-economic disadvantage are (once again) avoided: the consequence being 'community blaming'.

The neo-materialists have a point: the idea that community members should support one another, provide job networks and be a bit more friendly and integrated in order to reduce their health and socio-economic disadvantage does place responsibility for these issues back within communities or, at the very least, decontextualises these issues.

Whilst the neo-materialist critique is well supported by evidence in the case of national governments (see Chapter 3), it is harder to make the case that there has been a conscious or cynical retreat from the structural determinants (i.e. social determinants) of health disadvantage by those people actually conducting community based social capital research and interventions. It seems plausible
that, confronted with an inability to influence income redistribution or even to provide better services and amenities to communities, building social capital occurs as a reasonable alternative – community is the 'clay' with which they have to work. If anything, the proponents of social capital at this level are meticulous in not blaming the community for their problems (see for e.g. [158, 171]).

This does raise the question of whether the creation of social capital in particular locations or communities is actually likely to be an effective policy to reduce health disadvantage. Perhaps the most positive response to this question is: 'at the moment it is not possible to tell', and, certainly, there are grounds for being extremely circumspect about the use of social capital for this end.

In Chapter 2 the purported links between social capital and health at a population level was shown to be unproved and, quite possibly, spurious. This critique (at the time of writing) has not prevented the hypothesised 'social capital health link' from being used as a rationale for intervening to create social capital in disadvantaged communities (see for instance, [175, 472]). Chapter 2 also discussed social capital at an individual level; here, there is consistent evidence for social capital (or social connectedness) as being protective of health. Social capital has also been shown to diminish with income. However, there is quite a large leap from these two observations to claims that interventions to create social capital can reduce health disadvantage.

In fact the relationships between income, social capital and health are far from clear. In Chapter 2 it was established that, that even though people have less social capital as their income declines, social capital does not appear to mediate the relationship between low income and poor health. [159, 170] Thus a lack of social capital, like poor health, may be a consequence of lower income rather
than part of the causal sequence leading from low income to health disadvantage.

On the other hand, there is evidence of a small buffering or moderating effect for social capital on health (see Chapter 2). This could mean that social capital can potentially ameliorate some of the damage wrought by socio-economic disadvantage on health. This relationship is only potentially useful to reduce health disadvantage if social capital can actually be created – and this, as demonstrated, is a contentious issue.[475] Even Putnam, one of the originators and popularises of social capital, suggests that it cannot be artificially created (Putnam in [425]). Nor is it likely that a strongly connected and engaged community is something that can be created quickly: for instance, within intervention funding cycles. It is also necessary to ask whether artificially created social capital can endure for a sufficiently long period in order to have a positive impact on health.

In addition, assuming social capital could be created, there is great uncertainty as to exactly what this might mean. The studies in Chapter 2 used a wide range of measures of social capital, including such factors as 'trust', 'having people who can help in difficult times', 'voluntary work' and 'membership of community groups'. Clearly, social capital means a range of things to different researchers; it is also used interchangeably with a number of other terms (again see Chapter 2). Unsurprisingly, then, some of the key criticisms of social capital include that it is conceptually slippery, under-theorised and difficult to measure.[156, 425, 476]

There is also the issue of whether social capital should be tied conceptually to location – to ask why there is a suggestion that people in locationally disadvantaged communities need to develop social capital with one another.
Social capital, although affected by proximity, is certainly not confined by location; in large cities it would be expected that people would have links with a wide cross section of locations. It may in fact be a problem for people in disadvantaged locations that they are trapped within these locations and have a deficit of social capital connections beyond the confines of where they live.

7.6 Conclusions

This chapter has shown that locational interventions have achieved limited success in addressing the main socio-economic determinants of health, with a poor track record in producing lasting alleviation of locationally concentrated poverty or unemployment. From examining the international experience, it can be argued that locational interventions can never address the social and economic inequalities nor the current social exclusion contingent to capitalism, nor remedy the effects of inevitable recessions. It seems probable that a locational approach to addressing socio-economic inequality in Australia would face similar challenges. Quite simply, inequality is not caused fundamentally by locational factors, it is just manifested at this level.

Four types of locational policies were considered in some detail and, in general, it appears likely that the potential impact of these policies on health disadvantage is modest at best.

From an equity perspective, there is clearly a case for providing proportionately more health services to disadvantaged locations and ensuring that these services are of good quality. That is, given the populations of these locations, their need for health services is greater. However, this having been said, at present there is only enough evidence to predict a likely benefit to health of improvements in
health services in disadvantaged locations: the actual benefit and its magnitude requires further research.

Social mix offers two main potential benefits to health disadvantage: it can potentially reduce both the social stigma of particular locations and locational disadvantage (if it results in better local services and amenities).

Although such outcomes might be expected to benefit health, as yet there is no way of determining whether they do or not.

In regard to early intervention, the generally disappointing outcomes for these programs was surprising. It would be expected that these interventions would make a large difference to those involved, given the accepted importance of early life for health and a range of other outcomes and the widely held belief that early intervention is going to be helpful. The fact that they generally do not have a large measurable positive impact suggests that a degree of scepticism is necessary when early intervention is advocated as a panacea for socio-economic and health disadvantage. It also needs to be noted that those programs which have had the greatest positive impact have tended to be very expensive and intensive. Thus, if early intervention is to be advocated, it needs to be on the basis that adequate resources are allocated. Advocates also need to be mindful that early intervention means a range of very different programs and that using the unusual success of one small expensive program (e.g. Perry) to promote other quite different lower cost programs is simply not justified.

The findings for social capital were less surprising in view of the tenuous evidence for its impact on health disadvantage (see Chapter 2). It can be concluded that, despite the appeal of social capital within sectors of the public health community, at this point there are substantial barriers to its usefulness as
7. Locational approaches to addressing socio-economic disadvantage and health disadvantage.

a means of addressing health disadvantage. There is neither sufficient conceptual clarity as to what constitutes 'social capital' nor sufficient evidence of the efficacy of social capital interventions to improve health to justify attempts to create it to address health disadvantage.

The discussion in this chapter has focused on the evidence for the effectiveness of locational interventions in addressing the socio-economic determinants of health. Practitioners working within these disadvantaged locations and implementing the interventions face a whole set of challenges not reflected in the higher level data – it is their experiences that are the focus of the next chapter.
8. The Mt Druitt case study

8. The Mt Druitt case study

8.1 Introduction

Mt Druitt is a group of eleven suburbs in Sydney's west. The location embodies many of the lived realities of social exclusion: the suburbs have a high density of public housing, high unemployment, high numbers of sole parent families and poor transport and services. It is a difficult environment for the many health and community workers who work there; problems of socio-economic disadvantage are intertwined with those of crime, child abuse and neglect, domestic violence, illiteracy, high suicide rates, chronic health problems and premature death. It is precisely the kind of environment in which there is an apparent need for intervention and assistance. And, indeed, there are all manner of projects operating in Mt Druitt, all designed to improve the well being of the residents and community. Mt Druitt thus provides an ideal case study of what locational interventions can achieve in practice, and the challenges and possibilities that exist at this level of implementation. This chapter discusses a qualitative case study which explores the experiences of people working in Mt Druitt to reduce problems of socio-economic and health disadvantage.

In Chapter 1, it was explained that critical social science research is not limited to particular research methods: it is the manner in which the data is approached rather than the way it is collected which characterises critical social science. Thus, although this qualitative case study is a departure from the methods used in most of the research, it is included in order to illustrate the realities that confront people who are trying to create positive change in disadvantaged locations. In fulfilling this purpose, this study reveals some of the possibilities and limitations of a locational response to social exclusion, socio-economic disadvantage and health disadvantage. It demonstrates the types of factors that
8. The Mt Druitt case study

enable locational interventions to be successful in effecting change and achieving their aims, and also those that prevent them from succeeding. This discussion provides a practical dimension to the research by showing factors that may impede or assist a locational approach as it is implemented. It also illustrates a number of the themes that have emerged in the thesis; in particular, how issues of composition and context are manifested at locational level and how locational disadvantage differs across a location. It also demonstrates how an identifiably disadvantaged location can be used to attract funds and resources to bolster services and otherwise benefit socio-economically disadvantaged people.

In this thesis, health disadvantage has been shown to be largely a result of socio-economic inequalities. For this reason, the interventions examined in this study include those aiming to deal with issues relating to both health and/or socio-economic disadvantage. To this end, interviewees from health and sectors outside health were deliberately included in the study; namely housing, police, community, local government and church organisations.

This chapter begins with a profile of Mt Druitt (the study location), briefly examining its history and discussing the compositional, contextual and locational disadvantage issues. The method used in the study is then outlined, and tables presented of all the interventions in which interviewees were involved.
8. The Mt Druitt case study

A discussion and analysis of the interview data is then conducted – this:

- outlines the different interventions in which the interviewees were involved
- discusses examples of interventions which effected change
- analyses the processes involved in interventions which effected change, and
- analyses the main challenges (individual and systemic) preventing interventions from effecting change.

The data collected for this case study was obtained for the dual purposes of a funded research report and this thesis; all interviewees consented to this dual use. This chapter has some similarities with the report; however, the data is analysed here with the thesis aim as paramount. The research report received funding ($5000) from the Commonwealth Department of Health and Aged Care administered through the Centre for Health Equity Training and Research Evaluation, as a very small facet of a wider research project into determining the needs of the NSW public health workforce. At time of writing the resulting report has not been published.

8.2 Mt Druitt – location profile

Mt Druitt is a testimony to bad urban planning and design. It presents visible evidence of how housing and welfare polices can contribute to the concentration of disadvantage and locational disadvantage. The 11 suburbs (of which one is named 'Mt Druitt', to be identified for purposes of clarity as 'Mt Druitt (suburb)') stretching north from Mt Druitt railway station, it was originally conceived as part of a 1960s plan to decentralise employment and services.
8. The Mt Druitt case study

Around 20,000 houses were built for blue-collar workers by the NSW Department of Housing (DOH); however, the promised industry and jobs failed to eventuate. Today, large parts of Mt Druitt remain public housing, the tenants of which are mostly unemployed, single parents or aged and disability pensioners. The location is also used to house people in accommodation crisis, including people with mental illness, teenage mothers and around 240 newly released prisoners each year.[477]

The majority of housing was built according to Radburn planning principles, which aimed to create a sense of community through the way houses and open space were configured. Developments built using these principles are characterised by systems of pedestrian pathways, extensive use of open space and 'back to front' houses facing away from the street.[478] Unfortunately, rather than fostering community integration, the housing has reportedly contributed to opportunistic crime, a lack of privacy, neighbour disputes and access problems. In recognition of these issues, the DOH is currently overseeing a process of 'de-Radburnisation' as part of its community renewal program.

Unlike some other disadvantaged locations, Mt Druitt does not stand out physically as a slum: although modest, most of the housing is in good condition. There are numerous mature native trees and large amounts of open space. However, there are visible signs of a community under stress. Many local shopping areas are partially derelict and those shops that remain open are frequently heavily barred and unwelcoming; most local primary schools are encircled by barbed wire. The open space is not particularly useable, mainly being slopes of grass intersected by power pylons.
8. The Mt Druitt case study

8.2.1 Compositional issues

Mt Druitt is considered to be highly disadvantaged, with 8 of the 11 suburbs being identified as 'severely deprived';[479] as an indicator (using figures from the 2001 census), of a population of 50,800, 16% of people were unemployed, 22% were single parents and 21% of households have no car. Nearly a third (31.8%) of houses are owned by DOH. Mt Druitt has the highest Aboriginal population within the Blacktown LGA at around 5%, and around 32% of its population is born overseas (19% from non English speaking countries). There is significant demographic variance between the 11 suburbs; for instance, people speaking languages other than English varied from 12.2% in Lethbridge Park to 38.8% in Mt Druitt (the suburb) and single parent families ranged from 13% in Mt Druitt (the suburb) to 36.4% in Bidwill.[479]

In Chapter 6, the low income household densities of Sydney’s disadvantaged suburbs was discussed. Table 5 (below) shows the figures from a similar analysis for the suburbs of Mt Druitt, including:

- population densities for each household income cut-off
- percentage of families who are sole parents
- unemployment rate, car-less household rate
- a ranking by density earning less than $600 per week (for all Sydney suburbs see Chapter 6), and
- percentage of public housing.

As would be expected, the suburbs with the highest sole parent and unemployment rates are also those with the highest concentration of public housing.
Table 5. Mt Druitt: indicators of disadvantage (%)

<table>
<thead>
<tr>
<th>Suburb</th>
<th>&lt;$400</th>
<th>&lt;$500</th>
<th>&lt;$600</th>
<th>Sole parents</th>
<th>Unemployment</th>
<th>No car</th>
<th>Public housing</th>
</tr>
</thead>
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<tr>
<td>Bidwill</td>
<td>37.0</td>
<td>49.5</td>
<td>57.1</td>
<td>44.6</td>
<td>22.0</td>
<td>27.1</td>
<td>69.5</td>
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<td>Blackett</td>
<td>31.9</td>
<td>41.3</td>
<td>48.5</td>
<td>36.6</td>
<td>14.2</td>
<td>19.6</td>
<td>32.0</td>
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<tr>
<td>Dharruk</td>
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<td>25.0</td>
<td>30.5</td>
<td>22.3</td>
<td>9.5</td>
<td>9.0</td>
<td>12.0</td>
</tr>
<tr>
<td>Emerton</td>
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<td>40.3</td>
<td>46.4</td>
<td>31.0</td>
<td>15.2</td>
<td>20.4</td>
<td>28.0</td>
</tr>
<tr>
<td>Hebersham</td>
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<td>30.1</td>
<td>38.0</td>
<td>25.0</td>
<td>12.9</td>
<td>15.7</td>
<td>23.0</td>
</tr>
<tr>
<td>Lethbridge Park</td>
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<td>43.3</td>
<td>50.2</td>
<td>18.2</td>
<td>18.2</td>
<td>33.2</td>
<td>41.0</td>
</tr>
<tr>
<td>Mt Druitt</td>
<td>23.4</td>
<td>31.5</td>
<td>38.5</td>
<td>18.8</td>
<td>11.8</td>
<td>17.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Shalvey</td>
<td>28.5</td>
<td>38.7</td>
<td>46.4</td>
<td>34.6</td>
<td>16.2</td>
<td>17.1</td>
<td>44.0</td>
</tr>
<tr>
<td>Tregear</td>
<td>34.2</td>
<td>44.8</td>
<td>52.7</td>
<td>38.0</td>
<td>16.8</td>
<td>25.3</td>
<td>44.0</td>
</tr>
<tr>
<td>Whalan</td>
<td>33.4</td>
<td>42.7</td>
<td>49.8</td>
<td>32.7</td>
<td>13.7</td>
<td>23.1</td>
<td>39.0</td>
</tr>
<tr>
<td>Willmot</td>
<td>33.1</td>
<td>42.7</td>
<td>51.5</td>
<td>33.7</td>
<td>17.9</td>
<td>24.2</td>
<td>41.0</td>
</tr>
</tbody>
</table>

At a compositional level, these figures reveal a population that is likely to have a high need for health services and social support, and some suburbs are clearly far more advantaged or disadvantaged than others.

8.2.2 Contextual effects

In Chapter 4, contextual effects on health were defined as the extra burden on health which occur as a result of living in a location. Similarly, contextual effects can potentially occur for the socio-economic determinants of health so that, for instance, living in a particular location is associated with poorer school performance, greater chance of unemployment or increased exposure to crime. It has been proposed that contextual effects on the socio-economic determinants

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16 Sole parents as a percentage of families.
8. The Mt Druitt case study

of health may add to the overall burden on health placed by locations, (although recalling that contextual effects on health are generally modest). At this stage, there is not sufficient data to determine whether this tendency is the case or not; however, from observations in Mt Druitt, it is possible to see that there are some factors associated with this location which could exacerbate the socio-economic determinants of health disadvantage.

The local area police command reports very high rates of assault and burglary and reported incidences of domestic violence are the highest in NSW. Workers in Mt Druitt report observing dysfunctional behaviour in certain areas, including street drinking, vandalism, harassment for money, and young children wandering around unsupervised. Although local schools and educators were not included in the study, two interviewees stated that there were enormous problems with children's literacy in the area.17

Without a statistical analysis, it is not possible to isolate contextual effects; however, as was argued in Chapter 6, the effect of collective disadvantage and high support needs and/or of high rates of antisocial or dysfunctional behaviour can have consequences for people living in a location. Thus, for example, young people living in suburbs with high numbers of non working sole parents and with high rates of unemployment would have little access to employment referral networks. It may also be speculated that lack of contact with employed adults normalises unemployment, leading to an increased likelihood of this outcome (see Chapter 6).

There are also numerous problems associated with overburdened services; for example, one theme that emerged from the study was of health and welfare organisations struggling to cope with the demands that were placed upon them.

17 One of the interviewees coordinated a literacy teaching program in Mt Druitt for 20 years.
8. The Mt Druitt case study

The consequence of this is not just that people's needs go unmet but deeper ramifications for the strength and sustainability of an organisation; for instance, resulting, for instance, in high levels of staff burnout and turnover.

8.2.3 Locational advantages and disadvantages

In Chapter 6, it was argued that the term 'locational disadvantage' should be used to describe specific deficits in an area rather than as a general term for a socio-economically disadvantaged area. The suburbs of Mt Druitt exemplify this issue, with some suburbs suffering distinct 'locational disadvantage' whilst others are well serviced. For instance, there are a wide variety of community and health services and amenities in Mt Druitt, including community health centres, preschools, schools, a Westfield Shopping Centre, and service and youth clubs. There is also a train station at Mt Druitt (the suburb) and a private bus service. However, these services and amenities are not equally accessible across suburbs, with the outlying suburbs at a considerable disadvantage in this regard. Bidwill has no shopping facilities and shops in the other suburbs except Mt Druitt (the suburb) are minimal. This disadvantage is compounded by high rates of car-less households and relatively expensive and infrequent private bus services in most suburbs.
The study interviews showed that many residents of Mt Druitt are reportedly happy to live there and would not move if they could; but, for many others, the availability of public housing is the main reason for residency. People who have worked with the community for many years report both amazing resilience and also a deep sense of grief in many residents resulting from loss of place, of friends (when moving from other areas), and frequently of access to parents through separation or incarceration. A long-term worker in the area said that young people appear to lose hope as constant experience of failure creates a 'learned helplessness'; a similar loss of hope from constant 'knock backs' and lack of opportunities was observed by Peel in his study of Mt Druitt and other disadvantaged areas.[480]

8.3 Study method

The qualitative study involved interviewing 22 people working in the Mt Druitt and surrounding area who had been involved in or who had in depth knowledge of 'equity interventions'. Equity interventions were defined as activities designed to address socio-economic or health disadvantage which were undertaken in addition to the main business of specific organisations; for
8. The Mt Druitt case study

Example, the housing department’s urban renewal program (in which public housing areas are revamped) was undertaken in addition to its daily business of providing public housing. Interviews were conducted in the latter half of 2002. The purpose of the interviews was threefold:

- to gain information about the range of interventions occurring in a disadvantaged location at a particular time;
- to gather interviewees’ interpretations of intervention processes and outcomes, and
- to explore the ideas people working in a disadvantaged location had about the effectiveness of locational interventions to reduce health disadvantage and/or socio-economic disadvantage.

Interviewees included:

- (7) from health related services (Health Promotion, Aboriginal Health [including Daruk Aboriginal Medical Service] and Community Health)
- (3) from Blacktown City Council
- (3) from the Holy Family Church and Education Centre
- (1) from the Police Local Area Command
- (4) from the Department of Housing (including a group interview)
- (2) from small non-government organisations (Blacktown Alcohol and Other Drugs Family Service and Graceades Cottage), and
8. The Mt Druitt case study

- (2) from the NSW State Government funded locational initiatives, 'Families First' and 'Community Solutions'.

The first interviews were conducted with the priest of the Holy Family Catholic Church and the Director of the Holy Family Education Centre. A 'snowballing technique' of referrals was used from here. These two people were selected for the initial interviews because they have been working to address socio-economic disadvantage in the area for over twenty years and had a large number of 'contacts' (staff at the Education Centre collaborate formally and informally with a wide range of government and non-government organisations in Mt Druitt and the premises are frequently used as a venue for community consultations).

A sample size of 20 participants was selected, expanded to 22 in the final analysis in order to accommodate a group interview. The selection process for participants aimed to include a mix of health and non-health sector workers. People were included on the basis that they been involved in an intervention to address health inequities or socio-economic disadvantage and/or had knowledge of such interventions, due to their work role.

Face to face interviews were used in 18 interviews, with two conducted by phone. These interviews were approximately half an hour in length, although two follow up interviews were required for the Director of the Holy Family Education Centre due to the number of interventions in which she was involved. Each interviewee was given a description of the study to read, informed that the data would be used for this thesis and asked if they consented to this use. The interviews were semi-structured, where a list of set questions was used as a guide (see below), and elaboration was sought from the interviewee(s) by supplementary verbal questions during the interview, with
8. The Mt Druitt case study

questions such as 'Can you explain that in more detail?', 'Can you describe when that happened?', 'Why do you think that is the case?'

The initial set questions in each interview were:

- What is your role in your organisation?

- Can you describe the interventions to reduce the impact of socio-economic disadvantage in Mt Druitt in which you (or your organisation) have been involved?

- Why did you/your organisation undertake these interventions?

- What have been the outcomes of this/these intervention/s?

- What outcomes do you expect from this intervention? (if current)

- Why do you think the intervention was able to achieve this outcome?

- Why do you think this intervention was not able to effect change? (if that was the case)

- What factors do you think contribute to interventions which effect change?

- What factors do you think create a barrier to interventions effecting change?

- What do you believe is needed to resolve the socio-economic and health disadvantage of Mt Druitt?

Interviews were recorded using detailed notes which were then typed and analysed according to themes and categories (see below for analysis details). When follow up questions were required (for instance to clarify details), phone
and email were used. Documentation relevant to interventions (when available) was collected and used to confirm and support the information provided by the interviews. All respondents were given an opportunity to examine a draft of the findings from the interview process, and invited to offer clarification and/or further detail.

The data was analysed using a thematic analysis. This method of analysis is a well established means of analysing data obtained through qualitative interviews,[481, 482] involving the identification of distinct categories (or themes) into which the data can be sorted and so offers a logical way of presenting large amounts of interview data. Themes can be both pre-determined or allowed to emerge from the data.[482] In this study, the themes were largely predetermined with the interview questions designed to elicit specific information. The exception to this was that the categories within 'categories of interventions' were developed post interviews (see results section for categories). The selected themes are as follows:

- Categories of interventions
- Examples of effective interventions (those which were able to effect positive change)
- Defining 'effective interventions'
- Factors which contribute to effective interventions, and
- Challenges to interventions
  - intervention related, and
  - systemic
8. The Mt Druitt case study

Table 6 provides a summary of the organisation abbreviations used in the analysis.

**Table 6. Organisation abbreviations**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blacktown Alcohol and Other Drugs Family Service</td>
<td>BADFS</td>
</tr>
<tr>
<td>Blacktown City Council</td>
<td>BCC</td>
</tr>
<tr>
<td>Darruk Aboriginal Medical Service</td>
<td>DAMS</td>
</tr>
<tr>
<td>Department of Community Services</td>
<td>DOCS</td>
</tr>
<tr>
<td>Department of Housing</td>
<td>DOH</td>
</tr>
<tr>
<td>Holy Family Church</td>
<td>HFC</td>
</tr>
<tr>
<td>Holy Family Education Centre</td>
<td>HFEC</td>
</tr>
<tr>
<td>Western Sydney Area Health Service</td>
<td>WSAHS</td>
</tr>
<tr>
<td>Western Sydney Area Health Service – Health Promotion</td>
<td>WSAHS(HP)</td>
</tr>
<tr>
<td>Western Sydney Area Health Service – Community Health</td>
<td>WSAHS(CH)</td>
</tr>
<tr>
<td>Western Sydney Division of General Practice</td>
<td>WSDGP</td>
</tr>
</tbody>
</table>

8.4 **Categories of interventions**

Interviewees in the study discussed a wide range of interventions aimed at assisting the community. These are presented in Tables 7-11 according to the following categories:

- **Targeted service interventions**: services that had been designed or adapted to meet the needs of socio-economically disadvantaged individuals or groups; for example, outreach medical services.

- **Individual/family interventions**: aimed to create individual or family behaviour change or learning; for example, programs for new mothers.

- **Community interventions**: aimed to increase connections within a community, change community attitudes or develop community
8. The Mt Druitt case study

capacity to sustainably provide a service or continue an activity,
(either alone or as an adjunct to meeting the needs of individuals and families); for example, school breakfast programs.

- Physical environment and infrastructure improvement: aimed to physically improve housing, local amenities, infrastructure, or open space; for example, the DOH's Community Renewal program.

- Community intervention packages: the three NSW State Government funded intervention strategies, and the Blacktown City Council, Mt Druitt Area Plan (incorporating some of the projects from the above categories.)

Table 7. Targeted services interventions.

<table>
<thead>
<tr>
<th>Service description</th>
<th>Initiating org.</th>
<th>Partners/ contributors</th>
<th>Funding</th>
<th>Target groups</th>
<th>Duration/ type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Services</td>
<td>WSAHS</td>
<td></td>
<td>Health NSW</td>
<td>Community</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Outreach clinical services</td>
<td>DAMS</td>
<td></td>
<td>Health NSW</td>
<td>Aboriginal Community</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Drug and alcohol Counseling</td>
<td>BADFS</td>
<td></td>
<td>WSAHS</td>
<td>Individuals and families</td>
<td>Ongoing</td>
</tr>
<tr>
<td>After school program</td>
<td>HFEC</td>
<td></td>
<td></td>
<td>School children</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Emergency food relief</td>
<td>HFEC</td>
<td></td>
<td></td>
<td>People in need</td>
<td>Until 2000 replaced by food co-op.</td>
</tr>
<tr>
<td>Public housing outreach</td>
<td>DOH</td>
<td>HFEC</td>
<td></td>
<td>Aboriginal people in housing need</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
8. The Mt Druitt case study

<table>
<thead>
<tr>
<th>School breakfast outreach</th>
<th>DOH</th>
<th>HFEC WSAHS(HP)</th>
<th>WSAHS</th>
<th>Aboriginal families</th>
<th>Ongoing</th>
</tr>
</thead>
</table>

257
### Table 8. Individual and family interventions

<table>
<thead>
<tr>
<th>Project Description</th>
<th>Initiating Organisation</th>
<th>Partners/Contributors</th>
<th>Funding</th>
<th>Target Groups</th>
<th>Duration/Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literacy Program</td>
<td>HFEC</td>
<td></td>
<td></td>
<td>Children and adults with literacy problems</td>
<td>1984-1998 Ongoing</td>
</tr>
<tr>
<td>Soccer program</td>
<td>WSAHS(CH)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bush tucker tours</td>
<td>WSAHS(HP)</td>
<td>HFEC, local Aboriginal community</td>
<td>WSAHS</td>
<td>Mt Druitt Aboriginal families</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Aboriginal Martial Arts</td>
<td>Worker from DAMS</td>
<td></td>
<td></td>
<td>Aboriginal children and youth</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Mt Druitt Food Project</td>
<td>WSAHS(HP)</td>
<td>BCC</td>
<td>WSAHS</td>
<td>Mothers and babies</td>
<td>Short term</td>
</tr>
<tr>
<td>Breastfeeding Promotion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Sydney Young Families</td>
<td>WSDGP</td>
<td>Syd. Uni-Dept GP, WSAHS GPs Community Nurses</td>
<td>DHAC/General Practice National Innovations Funding Pool</td>
<td>Parents and babies</td>
<td>Pilot</td>
</tr>
<tr>
<td>Parenting programs</td>
<td>Graceades Cottage</td>
<td>DOCS</td>
<td></td>
<td>Parents</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Reconnect (youth crime</td>
<td>Local area command</td>
<td>Islander Community</td>
<td>Police (additional funds from Community Solutions)</td>
<td>Islander youth who have committed crimes or at high risk of doing so.</td>
<td>Pilot - then further programs planned.</td>
</tr>
<tr>
<td>prevention)</td>
<td>Police</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. The Mt Druitt case study

**Table 9. Community interventions**

<table>
<thead>
<tr>
<th>Project Description</th>
<th>Initiating organisation</th>
<th>Partners</th>
<th>Funding</th>
<th>Target Groups</th>
<th>Duration Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe communities – injury prevention</td>
<td>WSAHS</td>
<td>Mt Druitt Police BCC Wash House (women’s service) 42 other organizations</td>
<td>Funded under ‘Community Solutions’</td>
<td>Women/children suffering domestic violence Orgs. working in domestic violence prevention</td>
<td>Project - (basis for further initiatives)</td>
</tr>
<tr>
<td>(domestic violence prevention strategy)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food co-operative</td>
<td>HFEC</td>
<td>Food suppliers</td>
<td>Community</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Mt Druitt Food Project school breakfast</td>
<td>WSAHS (HP)</td>
<td>Local schools</td>
<td>NSW Health Aboriginal Health Branch</td>
<td>School children</td>
<td>Ongoing</td>
</tr>
<tr>
<td>program</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mt Druitt Food Project Healthy Canteen</td>
<td>WSAHS (HP)</td>
<td>Local schools</td>
<td>WSAHS</td>
<td>School children</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Aboriginal Men’s group</td>
<td>DAMS</td>
<td>DAMS</td>
<td>Aboriginal Men</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Mt Druitt Food Project Community Garden Bidwell</td>
<td>WSAHS (HP)</td>
<td>Gracedes Cottage and Tenancy Group DOH</td>
<td>WSAHS</td>
<td>Community</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Mt Druitt Food Project Community Garden Emerton (HFEC)</td>
<td>HFEC WSAHS(HP)</td>
<td>BCC</td>
<td>DHAC</td>
<td>Community</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Cooking classes</td>
<td>HFEC WSAHS Foodshare</td>
<td></td>
<td>Community</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Bridges Community Drugs Awareness</td>
<td>BADFS</td>
<td>WSAHS BCC</td>
<td>Community</td>
<td>Project (possible ongoing)</td>
<td></td>
</tr>
<tr>
<td>Foodshare</td>
<td>Graceades Cottage</td>
<td>Uniting Church</td>
<td>DOCS</td>
<td>Community</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Small Business building</td>
<td>BCC</td>
<td></td>
<td>Community</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Waste education Program</td>
<td>BCC</td>
<td>HFEC(community Garden)</td>
<td>Community</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
8. The Mt Druitt case study

**Table 10. Physical environment and infrastructure improvement**

<table>
<thead>
<tr>
<th>Project description</th>
<th>Initiating org.</th>
<th>Partners/contributors</th>
<th>Funding</th>
<th>Target areas</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community renewal</td>
<td>DOH</td>
<td>DOH</td>
<td>Bidwill, others to follow</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Mt Druitt Area Action Plan (physical enhancement options – including improved town signage and park committees)</td>
<td>BCC</td>
<td></td>
<td>Mt Druitt</td>
<td>Ongoing</td>
<td></td>
</tr>
</tbody>
</table>
8. The Mt Druitt case study

**Table 11. State Government funded intervention packages**

<table>
<thead>
<tr>
<th>Package</th>
<th>Components</th>
<th>Links to interventions (above)</th>
<th>Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families First</td>
<td>Early intervention</td>
<td></td>
<td>NSW Government</td>
</tr>
<tr>
<td></td>
<td>Home visiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improved service delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Solutions (including extra</td>
<td>Domestic violence prevention</td>
<td>Reconnect (expanding to include indigenous and</td>
<td>NSW Government (Premier's Dept.)</td>
</tr>
<tr>
<td>funding for boosting families first)</td>
<td>Crime prevention</td>
<td>non-indigenous Australians)</td>
<td>$2.4 million extension to Families First</td>
</tr>
<tr>
<td></td>
<td>Early intervention</td>
<td>Safe communities - Domestic</td>
<td>$2.8 million to reduce domestic violence</td>
</tr>
<tr>
<td></td>
<td>School holiday programs</td>
<td>violence/injury prevention</td>
<td>$750,000 to set up schools as community centres</td>
</tr>
<tr>
<td></td>
<td>After school care</td>
<td></td>
<td>$501,000 Gateways Program for 300 students at risk</td>
</tr>
<tr>
<td>Priority Regional Communities</td>
<td>Improved/integrated service delivery</td>
<td></td>
<td>$118,000 for Aboriginal women's safe place and domestic violence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>response service</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8.5 Effective interventions: examples and analysis

The main criterion for an effective intervention was that it contributed to improved outcomes for those involved and/or for the Mt Druitt community. This generally meant that the intervention met its original aims, for example, to improve literacy. In some instances, additional unintended benefits, such as fostering relationships between people or improving the working relationships between organisations, were also apparent. A number of the individual projects had been formally evaluated (including Bridges and the WAHS school breakfast program) but neither the wider effect of the interventions on the location (e.g. in decreasing unemployment rates or fear of crime) nor their long-term impact had been assessed.

The types of positive changes resulting from effective interventions included:

- providing a well targeted service
- improving the ambience of the community
- enabling individuals to positively redirect their lives, and
- improving the well being of the participants.

The next section outlines some examples of effective interventions, briefly discussing their main features; this is followed by an analytical section, where what constitutes 'effectively intervening' is examined. Finally there is a brief discussion of the interventions offered by the only faith based organisation in the study, because this organisation presents as a special case, raising some issues of the distinct operation of faith based organisations in disadvantaged locations.
8. The Mt Druitt case study

8.5.1 Examples of effective interventions (by category)

8.5.1.1 Targeted service provision

Targeted service provision is a form of vertical equity, where extra services are provided to those who are in most need of them (see Chapter 7). In Mt Druitt, it was evident that it was not just a question of providing more services but offering them in a way which increased the likelihood of utilisation. There are numerous individuals and groups in Mt Druitt who require specialised services that call for delivery in innovative ways, including indigenous people, caravan park residents, mentally ill people and people with disabilities. Interviewees provided a number of examples of successful targeted service provision which aimed to increase the levels and accessibility of services to particular groups.

Outreach services were used by a number of organisations to reach those who were either unable or reluctant for some reason to use centre based services, for example, Daruk Aboriginal Medical Service provided outreach services, and these were seen as overcoming access problems from lack of transport or the wariness of some indigenous people towards services which operated from premises which 'looked like a government department'. Another example of targeted outreach was that offered by Community Health to a highly marginalised caravan park community, where screening and other preventative services were offered on site.

The premises of the HFEC were used to site a number of services (including DOH, an after-school program and a school breakfast program). The purpose of locating these services at HFEC was to utilise the existing relationship between the HFEC and local community members, particularly indigenous people. That is, it was considered that services would be better utilised by offering them in a place already frequented and 'trusted' by marginalised people.
8. The Mt Druitt case study

Community health had also adapted some of its service provision in an attempt to better meet the needs of the local population and maximise the capacity to deliver services; for example, through providing generalist health teams with a mix of skills and knowledge (resisting the trend to specialised teams) and through a policy of offering opportunistic drug and alcohol advice where applicable.

8.5.1.2 Individual and family interventions

In discussions about where to intervene to create change, there is often some dispute whether to focus ‘upstream’ or ‘downstream’ (prevention, as is often stated, is usually preferable and cheaper than cure). However, when people have immediate issues or a particular need for information/education, it may be essential to provide interventions at the individual or family level. This type of intervention may also create collective benefits beyond those intended; for example, through the social contact of the participants.

8.5.1.2.1 Holy Family Education Centre (HFEC) Literacy Program

The HFEC literacy program ran for 16 years before it became too large to be manageable by the team of workers and volunteers (with over 800 participants, although not all were from Mt Druitt). It is of interest because it addressed illiteracy (a fundamental cause of disadvantage) and, according its coordinator, simultaneously contributed to the development of a strong community amongst the participants and provided the opportunities for building of supportive relationships and learning of other life skills.

Around one in five Australians are functionally illiterate[483] (anecdotally, the rates are higher in Mt Druitt). An often cited health risk of illiteracy is the inability to read instructions on children's medicines; however, the risk of
accidental poisoning is perhaps of little consequence when compared to the exclusionary and disempowering consequences of illiteracy. These include:

- limited employment and education options
- difficulties in everyday life (reading maps, shopping, catching buses, engaging with school and other institutions)
- risk of being 'ripped off' and deceived, and
- lowering of self esteem (feeling worthless and stupid and being treated as such).

The program began after it was observed that many of the people coming to the Holy Family Church for assistance in a crisis were also illiterate.

The HFEC literacy program was developed on the basis of research into best practice in teaching literacy. Reportedly, some participants benefited rapidly from the program and either improved their grades (if at school) or progressed to further education and employment. The principal benefit for others was improved relationships with their families, possibly as a result of their own enhanced self-esteem and ability to communicate. Additional gains included being better able to perform day-to-day tasks like paying bills and reading school notes to parents. As an adjunct to the literacy program, participants were also offered a chance to learn other skills (e.g. cooking), and all were able to share a meal together when they attended. It was perceived that, in addition to the literacy teaching, a 'community' grew up around the program, providing a focus, social contact and a friendship network for those involved.
8. The Mt Druitt case study

8.5.1.2.2 Reconnect

Crime affects health directly when people are injured as a result of assaults; it also contributes to the health eroding states of anxiety and sleeplessness.[187] For perpetrators, incarceration carries numerous serious health risks, including infectious diseases, drug related health risks and sexual assault.[484]. The Reconnect program run by Mt Druitt police involved Pacific Islander youth who had already committed serious crimes or were considered to be at high risk of doing so. It comprised sporting activities, prison visits, visitor talks and a ‘reverse role-play’ in which the police and youth played each other. The result, so far, has been a significant reduction in criminal behaviour by most of the youth involved, even though they continue to associate with their gangs. Also the program has received substantial funding to expand to other ethnic groups.

The engagement and behaviour change of the participating youth was attributed to three factors:

- parental, school and community leader support for the program
- interesting activities, and
- the clear explanation of the likely consequences of continuing to commit crimes.

It will be of interest to see whether the programs are successful in the long term and whether they can work as well with youth from other backgrounds.

8.5.1.3 Community interventions

8.5.1.3.1 The Mt Druitt food project: school breakfast programs

Not having breakfast before school is a nutritional deficit associated with a variety of behavioural and learning problems, as hunger and low blood sugar
make it difficult for students to concentrate. The school breakfast program is an example of a project which built the capacity of schools in the community to deliver a sustainable service. This project also illustrates the creative use of funding to benefit more than a stipulated target group.

Funding from the Aboriginal Health section of NSW Health was obtained to start school breakfast programs in local schools. Money was available as long as there were Aboriginal students at a school. This funding criterion enabled set up money to be given to the schools, to the benefit of all children, even if the school had only a few Aboriginal students in attendance. Funding was for set up costs (e.g. for food warmers) and the schools were supported to find sustainable sources of food. Thirteen schools participated in the project, and most had good participation (sufficient to warrant its continuation). Teachers reported improvements in student concentration and behaviour. The program is now run by the schools themselves.

8.5.1.3.2 Bridges Strategy

The Blacktown and other Drugs Family Service Bridges Strategy was based on the view that drug and alcohol problems can be better addressed when people understand the underlying issues, can appreciate others' points of view and have improved relationships with one another. Using performances, discussions, artworks and stories it aimed to create a strong foundation upon which drug and alcohol strategies could be based. Initially conceptually difficult and different to most 'anti-drugs' programs, Bridges was well supported, with around 30 organisations participating and 380 people (in total) attending 5 gatherings.

A number of positive elements emerged from the process according to the program organiser. It provided opportunities for dialogue for people who felt
8. The Mt Druitt case study

relatively powerless, it enabled a large number of organisations to work together, and adults and young people were able to understand one another better. Although at time of writing it was yet to be determined if this intervention strategy can reduce harmful drug use, it provides an example of how complex and underlying barriers (e.g. attitudes, ignorance, mistrust) to tackling a particular problem might be addressed. Other interviewees cited that this model would be appropriate to help address awareness of mental illness in the community.

8.5.1.4   Physical environment and infrastructure improvement

8.5.1.4.1 Urban renewal

DOH Community Renewal projects have been undertaken in a limited number of public housing areas, including parts of Bidwill in Mt Druitt. This process includes:

- refurbishing houses
- closing off walkways
- installing fencing
- enclosing open space into private backyards
- providing carports, and
- re-orientating houses to front onto the street.

Although it does not alter the concentration of welfare housing, it does remove the worst effects of Radburn design and provides residents with fresh, new-looking houses (public housing can often become very run down with only basic maintenance performed by the department). DOH staff report a range of psychosocial benefits. They claim that reducing the vulnerability to break-ins
8. The Mt Druitt case study

has lessened the anxiety people feel about being unable to protect their families – one man was reported to have said that he slept through the night for the first time in fourteen years after the walkway behind his house was closed. In addition, as residents can feel happier about their houses (or no longer embarrassed by them) they are more likely to invite friends over for social occasions (or even enter garden competitions).

The process is very expensive, however, and for this reason only small sections of housing can be improved at any one time. Unfortunately, this has led to resentment by tenants who have to wait for their areas to be fixed, particularly when they perceive that ‘bad’ streets are being attended to first (by which they meant those containing ‘troublesome’ tenants).

8.5.2 Analysis: what constitutes an ‘effective intervention’?

Examining the range and examples of effective interventions provides some insight into what constitutes interventions which can effectively alleviate aspects of socio-economic or health disadvantage. These components can be understood at four levels –

- Process level: did the intervention run?
- Scope of interventions: what was the range of problems to which interventions could be directed?
- Benefits of interventions: to what extent could participants be expected to benefit from the interventions?
- Defining ‘effective’ – differing views of effective
8. The Mt Druitt case study

8.5.2.1 Process level

At the level of process, having an effective intervention means, in the first instance, securing the necessary resources and staff time to set up and run and intervention. It is then necessary to have people from the target group participate in the intervention. With interventions intended to be ongoing, there is also a need for some means of ensuring sustainability beyond the initial resource allocation.

In regard to the first two measure of process for effective interventions it appears that many interventions are reasonably straightforward for organisations to organise and implement – that is, provided they have the resources and interest of participants there are a wide variety of types of interventions that an organisation might initiate successfully. However, more complex interventions requiring partnership arrangements or involving marginalised target groups, require more than simply securing resources then running the intervention. These issues are returned to below.

In regard to ongoing interventions, many were not sustainable beyond their funding cycle – that is, if ongoing funding was not able to be secured then the intervention would be expected to cease (e.g. Bridges and Reconnect). The question this raises is to what extent these short interventions are capable of effecting permanent positive change in individuals, given the complexity of problems many face. It can also be asked what benefit is provided to the local population in short term interventions, for instance, by providing a particular service for a short time, then removing it.

Interventions that had proved to be sustainable (i.e. ongoing for a number of years) tended to be built into the work practice of the organisation (e.g. outreach programs, the various HFC/HFEC activities) or were able to be sustained.
8. The Mt Druitt case study

without further funding. In the latter case, for instance, the school breakfast program was apparently sustainable as each of the schools took on responsibility for running the program at their school themselves and used donated food, rather than requiring ongoing funding.

8.5.2.2 Range of interventions

The interviewees were involved in a wide range of interventions (see Tables 4 to 8), these included, for example, community gardens, food co-operatives, early intervention, domestic violence prevention, literacy programs, and changing attitudes to drugs. Interventions were both aligned with the core business activities of different organisations (e.g. health, housing) and in areas well beyond what could be considered the focus of those organisations. Examples of those closely aligned with core business included WSAHS health promotion interventions relating to the health issues of food access, breastfeeding, and the DOH's main intervention relating to the renewal and reconfiguration of the housing stock. Interventions outside the realm of core business included: BADFS's 'Bridges' program (completed in addition to their main drug counseling focus); the AHS and the local Council supported the community gardens; the Police run 'Reconnect' was seeking to reduce criminal activity through an educational and sport style program (albeit not too far removed from Police and Citizen Club style activities).

In these latter instances, it was clear that organisations had some latitude to develop non traditional interventions. The rationale for this approach was that the problems experienced by their clientele were due to complex causes; that although people might become the concern of a particular organisation for a specific problem, (e.g. a health complaint or they were arrested), that problem was most likely due to a wide range of factors (e.g. dropping out of school could be a consequence of family breakdown, drug and alcohol problems and a
8. The Mt Druitt case study

learning disability). This broader thinking also accounted for attempts to include community development elements in some of more traditional interventions; for instance, although the DOH community renewal project largely focused on housing stock renewal it also supported a residents’ organisation and community garden. In a similar vein, the AHS interviewees stated they would like to do more community development, but lacked the time and resources to do so.

8.5.2.3 Benefits of interventions

The tables of interventions and examples of effective projects (above) demonstrate that the various organisations involved in the study were able to target some of the factors which mediate between socio-economic disadvantage and health outcomes. In essence, the interventions were concerned with making the experience of being socially excluded and socio-economically disadvantaged less onerous than it would otherwise be: minimising the damaging effects that are associated with socio-economic disadvantage, such as poor parenting, food insecurity, lack of preschool education, housing stress, school drop out and failure, criminal activity, violence and alcohol and drug abuse. Generally, it would not be expected that any of the interventions would of themselves result in a person improving their income or employment prospects dramatically (although some interventions, such as those addressing illiteracy or school retention, could clearly benefit a person's employment chances). Thus, although not aimed at the deeper determinants of health disadvantage, the interventions did aim to reduce the risks associated with socio-economic disadvantage to health and well being.

The scale of benefit likely to be achieved by these interventions would tend to be fairly small scale. Most of the interventions were inexpensive, of low intensity and of short duration, so it could not be expected that anything other than
8. The Mt Druitt case study

modest benefits would accrue to the participants (see Chapter 7). In terms of participants some of the interventions only catered for or attracted small numbers (e.g. the Council sponsored community garden only had a few regular attendees). Also, given that many residents faced multiple disadvantages (e.g. poverty, social isolation, substance abuse and mental health issues) it could not be expected that participation in one intervention could resolve these problems.

Having noted these limitations, it was apparent that there was a nascent trend of intervening to address the more complex causes of socio-economic and health disadvantage (see above); it was the intent of the larger Community Solutions package (not implemented at the time of the study) to improve linkages between organisations, increase early intervention, implement long term case management of 'problem families' and attempts to improve school and employment outcomes – thus, in this sense, it represented a more 'macro approach'.

8.5.2.4  Factors which contribute to effective interventions

Running an effective intervention is not simply a matter of having a good idea, finding funding, then doing it – interviewees also identified a number of more complex factors which they considered necessary or useful in creating a successful intervention in Mt Druitt. Examining these factors gives some indication of the degree of complexity that organisations can be confronted with when working in a disadvantaged location.

8.5.2.4.1  Building trust

Trust was a recurrent theme in the research, being viewed by interviewees as an essential contributor to the effectiveness of some interventions and quality service provision. It was observed that people would not use services they did not trust nor participate in interventions unless they trusted the people running
8. The Mt Druitt case study

them; for instance, a person may not admit to having an illiteracy problem unless they felt a degree of trust in the literacy program coordinators, not to mock them or consider them stupid. As a term used by the interviewees, 'trust' clearly related to a range of underlying factors, such as:

- reliability (e.g. turning up when they said they would, being open when stated).
- constancy (consistent staffing enabling people to deal with a known individual; an agency maintaining a long term presence in the area)
- participants being treated respectfully (e.g. rather, than say, as a welfare case)
- respect for cultural differences (e.g. respect for Aboriginal customs)
- consistency in service provision (people could expect particular quality of service)
- services being supportive in times of crisis (e.g. when a family member had died), and
- safety and confidentiality (e.g. not being 'dobbed in' to police, Department of Community Services, Centrelink or other authorities).

Building trust was also seen as a process taking time, which could take months or years. In these senses trust is actually a very difficult state to create between the workers within agencies and local community members. Many institutional factors are particularly likely to undermine trust or prevent it being built in the first instance. In particular, the high turnover of community and welfare workers and the large number of small projects and interventions was viewed as undermining the individual and community trust in the various
organisations operating in Mt Druitt – as witnessed by the reported comment: “Oh, another person sent to save us!” In addition, policies implemented by Centrelink and Probation and Parole were seen as highly damaging to trusting relationships between government organisations in general and the community; for example, when what were seen as mistakes or ignorance resulted in people losing benefits, being fined or incarcerated.

8.5.2.4.2 Community consultation

Community consultation is the process by which the community (i.e. representative organisations and individuals) is asked what 'it thinks and wants.' Of the interventions in this study, formal community consultation was only conducted as part of larger scale interventions; for example, the Community Solutions package and the family violence prevention initiative (see above) contained extensive community consultation components. The purposes of these consultations included engaging key community organisations, determining problems and possible solutions to problems. In these senses it can be seen that community consultation could contribute to creating successful interventions.

Clearly, community consultation can assist in identifying problems or nuances of problems that may not have been apparent to those planning to intervene; for instance, in the case of the family violence prevention initiative, it emerged from the consultations that addressing the problem would require both measures to keep victims safe and for work to be done with perpetrators. This consultation process also had the outcome of raising the political profile of the issue of family violence, a factor seen as contributing to the eventual outcome of the multi-million Community Solutions package (under which family violence prevention was funded).
8. The Mt Druitt case study

However, some of the longer time workers expressed some concerns about community consultation exercises that had been undertaken in Mt Druitt over the years, including the dangers of them being perfunctory or tokenistic; one interviewee commented about a particular instance: 'we had to make them do it again' (as the consultation had failed to include interested community members or consult properly with Aboriginal people). In addition, consulting effectively with marginalised groups requires a specialised effort that was not always apparent (see below for comments about Aboriginal consultation). Concern was also expressed that continual consultation could create 'false hope', in the sense that it was probable that many interventions were neither able to deliver substantial change nor address the fundamental problems in Mt Druitt.

Thus, getting community consultation 'right' is a fairly difficult proposition for those planning interventions in a disadvantaged location. To avoid criticism, sufficient resources need to be put aside to ensure it is done properly and tailored efforts need to be made to engage the most marginalised individuals (who may not wish to attend formal meetings). At the same time, those consulting would need to take care to clearly identify the limitations of what any resulting interventions could reasonable achieve; for example, people may wish to have local employment increased and drug dealing restricted, but all the intervention can realistically result in would be streetscape improvements and a youth employment intervention.

8.5.2.4.3 Working with Aboriginal people

The Aboriginal population of Mt Druitt faces issues of extreme socio-economic disadvantage, poor health and widespread abuse of alcohol and other drugs. There is, therefore, a high need for services and interventions. Interviewees who were Aboriginal and/or who worked with Aboriginal people considered that for
interventions to be effective there needed to be recognition of racism, the likelihood of distrust, cultural differences and the need for self-determination.

When it came to working successfully with indigenous people, it was clear that organisations needed to be culturally aware and, quite possibly, adapt their usual style of doing things. Interviewees reported that consultations and meetings with Aboriginal people could not necessarily be fitted into a quick schedule; rather, time needed to be taken to establish trust and rapport. In addition, there is not a cohesive Aboriginal 'community' which might be identified and consulted with but rather a range of different groups who are at times in conflict with one another. Thus organisations needed to take care not to offend factional leaders by inviting an unrepresentative range of people. It was also observed that organisations needed to recognise that Aboriginal people may be reluctant to use services that 'look official', that specific appointment times may be interpreted more generally, and that people who have 'no transport, phone or money' need to be accommodated.

A number of interviewees maintained that the principle of self-determination was the key to a better future for Aborigines. In practice, this meant that they felt that non-Aborigines needed to provide support to Aboriginal people when needed (e.g. venues or set-up assistance) but should stay out of decision making processes unless invited to participate.

Cultural sensitivity aside, there were clearly substantial barriers to Aboriginal people in Mt Druitt escaping social exclusion. One interviewee commented that every ethnic group had 'had their turn at the bottom' (i.e. at the beginning of a new wave of migration), but that Aboriginal people had never budged from this position.
8. The Mt Druitt case study

8.5.2.4.4 Partnerships

Partnerships between organisations were a common feature of intervention planning and organisation in Mt Druitt. The development of partnerships was often motivated by the view that it would benefit the operation of the intervention; for example, in the case of the community food garden sited at HFEC, Blacktown Council provided a project worker and the HFEC provided premises and a referral network of potential participants. Interviewees commented that organisations were also often compelled to form partnerships with one another in order to obtain funding for interventions.

The issue of partnerships did not emerge extensively in the interviews, with the exception of comments made by the director of one of the SNGOs. However, it was clear that successfully intervening also often involves an additional layer of activity in building relationships between organisations. This is an added demand on time on resources and involves the negotiation of issues of responsibility and power. On the latter points, the SNGO director noted that there were specific difficulties partnering with larger government organisations in ensuring that the SNGO was given due credit for its input and that they were partnered with appropriate level workers (e.g. managers rather than project workers).

8.5.2.4.5 Faith based organisations

The only faith based organisation included in the study was the HFC. It is illustrative to consider the role taken by HFC and its education centre (HFEC) in Mt Druitt as it highlights some of the differences between faith based and secular organisations.

At the time of the study the HFC and HFEC were running a highly diverse array of educational, welfare, employment and community services and interventions.
8. The Mt Druitt case study

from their Emerton premises (in addition to religious services). These included a
preschool, day care centre, food co-op, employment programs and holiday
programs. In addition, the HFEC premises are used as a community centre (for
formal and informal meetings, meals and contact for people) and provided
advocacy for many people (e.g. assistance with dealing with courts and welfare
organisations). It is also a site used by many other organisations in which to run
meetings, consultations, or to run interventions in partnership with the church
and education centre. The priest and director of the education centre had been
working in the location for decades.

The workers at the HFC and HFEC appeared to be able to contribute uniquely
to the community through a spiritual and philosophical commitment to social
justice and assisting socio-economically disadvantaged people, a long term
commitment to the location and the capacity to independently advocate for
people. It was apparent (both in the view of the HFC and HFEC workers and
interviewees from other organisations) that they were held in high regard by
many in the community and that high levels of trust were placed in the priest
and director. The church and education centre appeared to have much greater
latitude than most government organisations or government dependent
organisations (such as the SNGOs) to act independently, as most of their
activities were developed by them and self funded. The priest and workers were
not constrained by set working hours and conditions and would frequently
work well outside 'office hours'.

A faith based organisation (of the nature of the HFC and HFEC) clearly has a
differential capacity to intervene in a disadvantaged location than many secular
organisations. Even other faith based organisations would, in many cases,
struggle to provide a similar contribution without the necessary hierarchical
support, resources and commitment from individual religious leaders and
workers. Thus, replicating the interventions of the HFC and HFEC (in terms of numbers, range of issues, intensity or duration) would be extremely difficult for most other organisations.

8.5.2.4.6 Coordinating locational responses

There are a large number of government and non-government organisations operating to serve the Mt Druitt population. Coordinating the activities of these organisations was a keenly perceived need. Some of the problems of a lack of co-ordination included: a narrow focus of organisations only interested in their own area, the lack of an overall locational policy, poor communication between (and within) organisations and no single coordinating organisation. A reflection of the concern these problems were creating was in the existence of four separate projects all aiming to get organisations to work better together:

- 'Mt Druitt Area Action Plan' (BCC funded)
- 'Priority Regional Communities'
- 'Families First', and
- 'Community Solutions' (all State Government funded).

The fact that all these 'co-ordination initiatives' started independently of one another but covered substantially similar ground could be seen as further evidence of an inability to coordinate. However, the organisations involved, upon noticing the similarity of their objectives, were able to rationalise the projects and work together. Community Solutions largely subsumed PRC and Families First, bolstering the projects included in these packages.
Differing views of effectiveness

The interpretation of effectiveness was also explored with interviewees: what they were trying to achieve and why. There was some variance in views between government and non government agencies.

For government agencies, what constituted a potentially effective intervention largely depended on the function of the agency in question. On the whole interventions run by government agencies were well within the realm of concern of their core business. For example the main intervention of the Department of Housing was in improving the amenity of its housing stock; Community Health focused on prevention and access to health services; the police were trying to reduce young people’s involvement in crime. Thus in this sense, interventions were considered effective if they addressed a problem of concern to a particular agency.

Clearly, many interviewees were of the opinion that although this singular approach could influence specific issues, it was not going to be effective in addressing the complex problems of individuals nor of the area as a whole. This view was reflected in the widespread support for the cross agency area level interventions planned (see below).

The non government agencies had differing views of what constituted effectiveness. For instance, as apparent in the HFEC’s literacy program. Although at an instrumentalist level, teaching literacy skills was viewed as very important (the learning time was considered ‘sacred’) – so too was the development of a supportive community amongst the participants. Regular shared meals were held and participants were encouraged to interact and support each other.
8. The Mt Druitt case study

There was also explicit recognition of the value of symbolic and spiritual contribution made by the church and education centre, for example as in the facilitation of burial and commemoration services for indigenous people and of the organization of holidays for local children. These activities didn’t achieve ‘measurable outcomes’ but were seen as contributing to individual and community identity and respect for self. In these senses, effectiveness was viewed by the Church and education centre as a more multilayered concept.

The view of effectiveness implied in the NGO run Bridges program also differed from that of the government run interventions. Although ostensibly a drug prevention program, it focused almost entirely on building better relationships and getting young people involved in activities – with minimal drug education or traditional drug prevention work. Thus, effectiveness was measured (to the extent that it could be) by the opportunities the Bridges program provided for interaction between individuals and for participation in youth activities, not on drug usage or harm amongst young people.

8.6 Challenges to interventions

Successfully intervening in Mt Druitt is challenging at both an organisational and systemic level. Organisation level challenges refer to factors which limited the capacity of the various organisations to intervene to the extent they desired, or which resulted in the failure of individual interventions. Systemic level challenges refer to the factors which generally make intervention difficult in Mt Druitt, for instance relating to the characteristics of the location and population. Challenges at both levels resulted in incipient interventions failing to eventuate,
8. The Mt Druitt case study
and in implemented interventions being stopped prematurely or not meeting
some or all of their aims. Exploring these challenges illustrates some of the
barriers to intervening successfully in a disadvantaged location.

8.6.1 Intervention/organisation related
8.6.1.1 Organisational capacities

The majority of the interviewees indicated that their organisation was
continually stretched by a constant high demand on their services from
residents, many of whom faced chronic and complex problems. For these
reasons, the capacity of organisations to intervene in a preventative way was
seen as limited, in that 'day to day' demands needed to be met first. In some
instances interviewees expressed the view that they or other workers in their
organisation would have liked to have been involved in more interventions to
create change, but it was actually very difficult to do so given their work
demands. This issue was illustrated by the reaction to the multi-million dollar
Community Solutions package: in the view of Community Health and AHS
workers, the large injection of funding would enable interventions to address
some of the most challenging problems (e.g. domestic violence and families with
multiple serious issues) – interventions that had not been possible with the pre-
existing levels of resources.

SNGOs also faced significant difficulties in sustainability and meeting the
demands placed upon them. Large amounts of time need to be devoted to
matters outside their core business (e.g. funding and grant applications and
program evaluations), and specialist workers were finding that they were
required to perform increasing amounts of administration when support staff
hours are cut back. As a sector, the continuing existence of SNGOs is threatened
by the trend to outsource community services to large organisations.
8. The Mt Druitt case study

8.6.1.2  *Funding and funding cycles*

Secure funding was an issue for many organisations, particularly the SNGOS. Short-term funding cycles created uncertainty within organisations as workers often did not know whether a particular project could continue beyond it funding cut-off (or, indeed, if they would even have a job). There was a particular concern about the amount of time workers had to spend securing ongoing funding at the expense of other activities.

At a project level, the reliance on one to three year funding and project specific funding creates a tendency for a series of disconnected 'one off' initiatives aimed at fixing isolated problems; for example, the Reconnect Project (as it was originally conceived) demonstrated short term benefits in reducing gang related crime but was not followed up with programs to ensure the youths gained further education and employment. The shift to packages of funding (i.e. funding a multiple of related interventions) is recognition of this problem and the need for more integrated solutions, although there is no guarantee that this approach will continue beyond the three years of funding.

8.6.1.3  *Worker issues*

Working in service organisations in Mt Druitt is very demanding and challenging. For this reason, it attracts many highly committed people, but the nature of the work, combined with generally low pay and levels of support, results in a high worker burn out and turnover. One of the consequences of this worker transience is that relationships between workers and community members constantly need to be rebuilt: clearly, a constant stream of new people coming into a community can erode the trust of local people in the organisations working to assist them.
8. The Mt Druitt case study

Utilising volunteers also creates difficulties. Projects based on volunteer effort can founder when the demands are excessive and also when the volunteers inadvertently patronise community members (a problem occasionally experienced at the HFCEC). A number of interviewees noted that once volunteers became skilled and confident they would often leave Mt Druitt entirely ('they just move away'). and the organisation would need to train more volunteers. In one way, this is a measure of the contribution of voluntarism to individual development but, if a widespread pattern, it does not contribute to the community as a whole (although some organisations accepted this attrition as inevitable and see the training provided as having value in itself).

8.6.2 Systemic problems

8.6.2.1 Ad hocness

International locational approaches to social exclusion and socio-economic disadvantage were examined in Chapter 7. One of the principal shortcomings observed was that locational approaches often consist of numerous *ad hoc* measures, lacking any overall cohesiveness. A similar observation can be made about the interventions operating in Mt Druitt at the time of the study. Although there were a wide variety of interventions in that location at that time, they were not guided by a consistent philosophical or policy approach, nor were most of them part of a program to address the multiple and linked dimensions of social exclusion. In practice, the locational interventions were a series of fairly disconnected responses by organisations responding to perceived needs in the location in which they (or part of their organisation) were situated. Thus, many of the interventions that occur on a day-to-day basis are those addressing very specific problems, rather than part of a general plan with societal and locational level outcomes.
8. The Mt Druitt case study

At an individual and family level, a lack of cohesiveness also creates difficulties. In Mt Druitt, like other disadvantaged locations, the effects of disadvantage are spread unevenly, with some individuals and families experiencing far more problems than others. For these people, a series of disconnected programs may be of little value – for instance, if an effort is made to keep a child at school but parental substance abuse and violence problems are not addressed. As acknowledgement of this problem, one of the key initiatives vaunted for the Community Solutions intervention package is to intensively case manage 'problem' families across organisations.

8.6.2.2 Welfare issues: housing and ‘welfare dependency’

In Chapter 6, the problem of public housing as perpetual welfare housing was discussed: in essence, public housing in Australia is synonymous with welfare housing, firstly because this constitutes initial eligibility and secondly because secure employment provides a strong incentive to leave public housing (as rents increase to market value). This latter issue was observed in Mt Druitt, where people who are able to obtain secure jobs and better incomes leave the location to move somewhere more desirable. Therefore the more capable and advantaged members of the community are also likely to be quite transient. This transience is likely to result in a reduction of potential role models of employed people and a reduction in the pool of skilled volunteers to be utilised by organisations.

8.6.2.3 Long term disadvantage

For a number of reasons, it is often very difficult to assist people who have been socio-economically disadvantaged for long periods of time. This is illustrated by the problem of long term unemployment; people who have been out of the workforce for a long period of time lack not only job skills but also the
8. The Mt Druitt case study

knowledge of how to 'act' at work, including understanding the 'language of instruction' (i.e. following directions). It was observed that these issues can create problems when people were undertaking employment training or were receiving supervised employment as part of their community service order. Overall, the HFEC found that assisting the long term unemployed into employment requires intense training and supervision.

It was also noted by some interviewees that welfare dependency was another impediment to people moving out of disadvantage – where recipients of various forms of social assistance have developed a reliance on this assistance to the extent that they are prevented from 'helping themselves' from ever moving out of welfare dependence. It was also observed that people on very low incomes may use services in a way unintended by the organisers; for instance, food relief intended for those in crisis ended up being expected ('budgeted in') by some struggling families.

8.6.2.4 Intransigent problems

Some of the most difficult challenges for the Mt Druitt population lie with issues well outside the influence of individual organisations or partnerships of organisations. Challenges of this nature cited by interviewees included macro issues such as unemployment, lack of transport, gambling (the large 'pokie palaces'), easy availability of alcohol and lack of shops and facilities.

The transport problem is illustrative of the substantial difficulties faced by those seeking to reduce locational disadvantage in Mt Druitt. Some suburbs were well serviced with bus and train services (e.g. Mt Druitt [the suburb]), whilst others had very limited bus services that would make getting to work by bus highly problematic (e.g. Wilmot). Attempts had been made to solve this problem but had proved unsuccessful, as the State Transport Authority had been unwilling
8. The Mt Druitt case study
to become involved. This demonstrates how a particular problem for which there is an apparent solution can be stymied without the necessary support of controlling interests.

Gambling was also a seemingly insoluble problem, with large quantities of some individual’s welfare benefits disappearing into gambling machines in pubs and clubs. The existence of gambling venues was viewed as being highly detrimental to the community – especially in terms of removing money that should have been spent on essentials.

Similarly, pubs with 24 hour licences were also seen as very problematic, fuelling alcohol related problems including excessive drinking, domestic violence, other interpersonal violence and child abuse and neglect. Of course, the organisations operating in Mt Druitt had no control over the existence, opening hours or operating guidelines of these private businesses, with well appointed gambling and drinking venues located in suburbs with few or no shops or other facilities.

It also appeared beyond the capacity of the study organisations to provide adequate shopping facilities in all the suburbs of Mt Druitt (although the HFC runs a food co-op on some days). One interviewee commented that it was ‘easier to buy drugs than milk’ in some suburbs. The establishment and operation of suburban shopping centres was an issue in the control of private businesses, with problems of theft, vandalism and violence creating a deterrent to do so. As an illustration of these issues, a previously struggling centre in Lethbridge Park had become functional and well utilised once a security guard was employed to deter antisocial activity; however, this was something arranged by the owner of the shopping centre.
8. The Mt Druitt case study

8.6.3 Can the problems in Mt Druitt be addressed by locational interventions?

At the conclusion of each interview, interviewees were asked what they understood to be the deeper causes of inequality in Mt Druitt – and whether these issues could be addressed by organisations working in the location. This section discusses and reflects on their responses.

All the interviewees were aware of the deeper causes of social exclusion, socio-economic disadvantage and health disadvantage, expressing the view that these issues were a result of the complex interactions between individuals, their families and the place and society in which they lived. Although they recognised human agency, for better or worse, they also saw that in many instances the problems encountered by people in Mt Druitt were due to issues over which they had little control, such as high rates of unemployment, overburdened services, ongoing poverty, exposure to excessive crime and violence, locational disadvantage (e.g. poor transport and facilities) and institutional indifference. Many expressed frustration at the failure of necessary changes to eventuate (in particular, an employment policy for western Sydney and transport improvements) and also at the legacy of bad planning with which they had to deal.

Some interviewees felt that Mt Druitt's problems were actually getting worse, despite a plethora of interventions over many years. Indeed, reports on the issues facing DOH tenants in Mt Druitt from the early 1980s discuss very similar problems.[485, 486] It is possible that the perception of worsening problems is accurate, particularly given the increasing numbers of people with very high needs being housed there in recent times (as a DOH area of 'last resort').
The issue of what was required to address the problems in Mt Druitt (i.e. 'what would really effective intervention look like?') elicited a range of diverse responses. Some of the answers were almost flippant (e.g. several interviewees responded with 'millions of dollars!') which, upon probing, reflected a view that the aggregate problems of Mt Druitt were not really solvable. A similar, if more morally complex, attitude underlies responses from the Holy Family interviewees, who saw one of their roles as 'bearing witness to their struggle' (i.e. they saw moral value in compassionately witnessing the difficulties faced by local residents). Others emphasised the importance of employment, better funding for services and targeted interventions (of the types outlined above). Some interviewees gave the impression that this question was not particularly relevant, so pressing were the demands of responding to constant crises and the day to day needs of their clients.

At the time of the study there was only one clearly articulated plan to change Mt Druitt from a disadvantaged location into a mixed income location: namely, to change the social mix of the area through selling off parts of DOH holdings to private ownership. Currently, around 30 to 40 houses are sold each year but the intention (at time of writing) was to do so on a far larger scale and change the social mix of the area. This would occur through the mechanism of private buyers moving into the area and DOH tenants being placed into other suburbs. This idea was generated in the middle echelons of the DOH. Neither knowledge of nor enthusiasm for the idea was in evidence amongst the interviewees from the local DOH office; in essence, they saw their business as a social housing provider (and, too often, reluctant social worker), but not as social engineer.

The 'mixed blessings' of social mix were examined in the previous chapter, and the probable effects on tenants in Mt Druitt of any plan seem similarly ambivalent. On the positive side, reducing the concentration of disadvantage
could potentially be expected to dilute the associated high rates of violence, joblessness and child abuse and neglect, possibly enabling services to better meet these challenges and diminishing any 'normalisation effect' (if it does exist). It may lead relocated households to have better access to basic services like shops and transport – although these services could clearly be provided without dismantling the public housing estate. Children could benefit from attending schools handling a lower number of welfare and literacy problems. For people living in the most structurally problematic parts of Mt Druitt, (i.e. multiple occupancy dwellings and houses all 'looking in' at one another) shifting to another suburb could mean shifting to improved housing. However, as has been discussed, relocation itself cannot solve unemployment, the stress of being a sole parent, social isolation or problems that lie within individuals and families. It also places at risk the friendships and relationships people have built up over years of living in the location.

8.7 Conclusions

This case study of Mt Druitt has examined:

- the positive results interventions in a disadvantaged location can achieve
- the complexity involved in effectively intervening, and
- some of the organisational and systemic barriers to reducing socio-economic and health disadvantage through locational level interventions.

Mt Druitt is an ideal location for examining these issues: it is typical of the large welfare housing estates in Australia's major cities and is the focus of numerous organisations intervening in attempts to alleviate the problems in the location.
8. The Mt Druitt case study

When considering what can be potentially be achieved by interventions, a number of conclusions can drawn. There is a high level commitment amongst people working in Mt Druitt to improve well being and opportunities for local people. From their reports, it is clear that it is possible for organisations to develop and resource a wide variety of interventions, often directed at issues outside the 'core business' of their organisation. A number of successful interventions were reported, including those which improved literacy, provided breakfast for school children, reduced criminal activity and enhanced urban infrastructure. In addition, the collective lobbying and activity of local organisations and people resulted in a multi-million dollar spending package being directed to Mt Druitt.

It is conceivable that health benefits could accrue from the many interventions in Mt Druitt. They are directed at some of the myriad factors which mediate between income and health (or buffer a person against the health damage wrought by poverty) – covering such issues as access to health services, literacy, family violence, drug use, suburb stigma, early intervention, and social connections and support. For some individuals, involvement in specific interventions was reportedly highly beneficial (e.g. those who moved from illiteracy to literacy). However, it would be expected that the impact on socio-economic and health disadvantage of these interventions would be generally fairly modest, given that they were mostly of short duration, low intensity and disconnected from other interventions.

It is apparent that intervening effectively beyond minor level programs (e.g. cooking classes or the like) can involve considerable complexity. Thus, it is not simply a matter of developing an idea and finding the necessary resources to achieve success. In many cases the outcome of interventions was influenced by interpersonal and inter-organisational relationships. Trusting relationships with
The Mt Druitt case study
target users were viewed as important, or even essential, with trust building a process which can be time consuming, with a tendency to be undermined by the short term nature of many interventions. Requirements such as community consultation and partnership building added further demands to organisations, although potentially increasing the reach and effectiveness of various interventions. Also, when these processes are not performed with due care there is a risk of undermining trust or reducing the potential of interventions (e.g. by 'raising expectations' or alienating partners).

Working with highly socially excluded groups can be challenging, particularly when there is a history of mistrust and cultural differences; this adds further difficulties for those intervening when they wish to consult with these people and ensure their participation. These problems are of particular importance in the case of indigenous population of Mt Druitt: despite numerous helping efforts and the sensitive and supportive attitudes of many workers in the area, the social exclusion of this population seems entrenched.

The single faith based organisations in the study appeared to have a unique capacity to deliver an extensive range of services, interventions and advocacy to the community. However, this 'model' is unlikely to be easily replicable, being dependent on the strong faith and long term commitment to social justice of its key workers.

There are numerous challenges that limit potential interventions and what they are likely to achieve. Organisations often have highly demanding workloads and little capacity to move outside day to day concerns. Smaller organisations sometimes feel continually under threat and are forced to focus on survival issues in addition to their work: funding for interventions is usually of limited duration and organisations are forced to devote their time and resources to
8. The Mt Druitt case study

ensure funding is ongoing. For these reasons there are considerable pressures on individual workers, who not only have to work with highly demanding clients and difficult issues but often also face low job security due to the limited funding cycles of many projects.

There are also substantial challenges to addressing the deeper determinants of socio-economic and health disadvantage in Mt Druitt. Despite various plans to better co-ordinate efforts, there was no overarching plan governing all interventions in Mt Druitt. This meant there was no common sense of purpose to interventions and little cohesiveness around all the work different organisations were performing, and also a small likelihood of people benefiting from interventions across their lifecourse. Some problems appear simply insoluble – for instance, if the relevant government department refuses to participate in addressing an issue. Problems related to the operation (or non-operation) of private enterprises appeared difficult to influence. Thus gambling and drinking venues operated virtually unchecked and shopping facilities remained non-existent or limited in some suburbs.

Of course, as long as Mt Druitt remains a public housing estate the socio-economic profile of the location can never improve. It may also always be stigmatised. But it is useful to consider for a moment what is idealistically possible to address the factors which link health and income.

People in Mt Druitt could, for instance, regardless of their income, have:

- high quality and accessible health services (including outreach to isolated people)
- mental health services
- employment opportunities
8. The Mt Druitt case study

- first rate education
- good quality frequent public transport
- secure and attractive housing
- adequate shopping facilities
- quality early childhood services and education
- social support
- assistance to change unhealthy behaviours, and
- normal (for NSW) levels of crime, family violence and drug and alcohol abuse.

Clearly, some of these issues can be touched upon some of the time but the funding, resources, organisational capacity, lack of influence over private businesses, co-ordination between organisations, lack of outside organisation support and sheer difficulties of working with long term socio-economically disadvantaged people make meeting these ideals challenging – if not impossible – to meet. It would be expected that other disadvantaged urban locations in
8. The Mt Druitt case study

Australia would face similar challenges. Overall, whilst the commitment and innovativeness of the organisations and people working in Mt Druitt is impressive and the work they do of great value, the odds are stacked against them ever resolving the problems that are manifest in the location.
9 Discussion and conclusions

9.1 Introduction

This thesis set out to examine whether systematically intervening in disadvantaged locations (a locational approach) can substantially reduce the excess burden of death and disease (health disadvantage) faced by Australia’s socio-economically disadvantaged urban residents. At the commencement of research such an idea seemed both possible and practical. The British government had recently18 funded an extensive locational approach to address health disadvantage. Although there was no similar initiative in Australia, there has been a history of Australian governments (mainly state) spending money to intervene in disadvantaged locations to improve the social and economic well being of residents. The primary research question at issue was whether there is evidence to indicate that a locational approach can improve the health of the socio-economically disadvantaged urban population (defined as approximately the lowest 25% to 30% of income earners). In practical and policy terms, the findings from investigating this question can indicate whether or not there is a justification for increasing resources allocated to disadvantaged locations in order to improve health.

The thesis was written from the perspectives of political economy of health and critical social science. Taking this perspective involved placing the research question in its contemporary context, namely considering the influence of socio-economic and political factors in both creating the problem of health disadvantage and enabling or constraining possible solutions. The research synthesised findings from cross disciplinary research, drawing from

9. Discussion and conclusions

epidemiology, health social science, political economy, social theory and original demographic and qualitative research.

In brief, the thesis found that a locational approach can, at best, have a modest impact on health disadvantage for a minority of socio-economically disadvantaged urban Australians. This chapter concludes the research, drawing from the evidence and findings developed through the thesis. Also discussed are:

- the contribution to knowledge made by this thesis
- the limitations of the research
- the original contributions made in the research, and
- possible directions for future work.

9.2 Health disadvantage: causes and solutions

9.2.1 The primary role of socio-economic factors

The first question asked in the thesis was, what causes health disadvantage? Or, in other words, why do socio-economically disadvantaged people have worse health than the rest of the population? The reason for asking this question was that it was necessary to clarify what causes the problem of health disadvantage before evaluating potential remedies to the problem, including that of a locational approach. This question was examined in Chapter 2 through a critical review of the health inequalities literature.

This chapter concluded that there is robust evidence that socio-economic disadvantage across the life course damages health; and that the pathways between socio-economic disadvantage and poorer health include reduced
9. Discussion and conclusions

resilience to health adversity and a substantial increase in the likelihood of health damaging behaviours.
More specifically, it is apparent that poorer health outcomes are a result of factors associated with socio-economic disadvantage, including,

- unemployment
- sole parenthood
- higher job related stresses
- disadvantage in early life, and
- lack of access to quality health and human services.

Whilst there is a consensus amongst researchers that these factors cause poorer health and increase the likelihood of risky healthy behaviours, Chapter 2 analysed the has been extensive debate about the causal mechanisms which explain how socio-economic factors damage health. This debate was analysed in Chapter 2. Psychosocial theorists have argued that psychosocial stress is the primary mechanism to explain the link between socio-economic status and health outcomes in affluent countries. They argue that lower socio-economic status creates a psychosocial burden on people which damages their health, independent of their material well being. By contrast, neo-material theorists assert that a lack of material resources, and deficits in the provision of welfare and social infrastructure are the primary causes of socio-economically patterned health inequalities.

In Chapter 2 it was shown that there is evidence for both positions. There is evidence that both material and psychosocial factors can damage health. It was argued in Chapter 2 that the differences of view can be largely be reconciled, especially when it comes to identifying the causes of the poorer health of the lowest socio-economic status groups. Quite simply, reducing poverty,
9. Discussion and conclusions

addressing material disadvantage and improving human services could also be expected to reduce many of the psychosocial stresses associated with low socioeconomic status. Although it does need to be acknowledged that psychosocial stresses resulting from the way work and society are hierarchically organised would require other measures than increasing incomes and improving service provision.

It was also shown in Chapter 2 that there that the hypothesis that income inequality damages health through undermining trust and social connectedness (social capital) is largely unsustainable. A modest relationship between income inequality, eroded social capital and measures of population health has been observed in the United States, but similar effects have not been found in other countries. Having said this, income inequality is still an issue of critical importance in understanding the development of health disadvantage. This is because the distribution of income affects what proportion of the population is socio-economically disadvantaged and hence disproportionately exposed to the adversities which damage health; reducing income inequality can also be expected to improve health through raising the living standards of socio-economically disadvantaged people and reducing individual psychosocial stress.

There is a consensus among health inequalities researchers that health disadvantage is a problem which occurs in the context of social and economic inequality.
Overall, it can be concluded from the discussion in Chapter 2 that if a locational approach is to be effective in reducing health disadvantage, it needs to be able to:

- reduce socio-economic disadvantage (e.g. low income, unemployment) at least in part, and/or
- provide a buffer against the effects of socio-economic disadvantage (e.g. through improved health service provision, early intervention services).

9.2.2 **Possible solutions**

In Chapter 3 it was shown that health inequalities researchers also agree that the problem of health disadvantage requires social and economic solutions. Representatives of both the psychosocial and neo-materialist approaches have suggested fairly similar measures, despite different understandings as to why such solutions might be effective. In particular, there is agreement that income redistribution is the most important step that governments can take to reduce health disadvantage. This measure would raise the incomes of the poor and hence reduce the material and psychosocial disadvantages they face.
They also assert that a range of other social support and equity measures are necessary, such as:

- providing free or subsidised human services to socio-economically disadvantaged people, (e.g. housing, health, education, transport)
- addressing the causes of socio-economic disadvantage (e.g. employment creation, job training and reducing early school leaving)
- creating a more socially equitable society (e.g. through promoting human rights and social justice), and
- reducing the impact of socio-economic disadvantage on health (e.g. early intervention, targeted health services).

It is clear that many leading health inequalities researchers believe that generalist and macro level policies and interventions are what are primarily needed to reduce health disadvantage (see policies and interventions listed above). By contrast, support for a locational approach is not strongly apparent in the research literature. Even in the UK, where the government was [at time of writing] addressing health disadvantage through a locational approach, support is weak. Among researchers, views on the usefulness of intervening at a locational level extend from a perception among psychosocial theorists that it could be a useful adjunct to macro level policies, through to the argument from neo-materialist theorists that it would detract from what is really necessary to address health disadvantage.

When it comes to formulating possible remedies to health disadvantage, Chapter 3 asserted that the analysis of these theorists is reasonably sound. Where their analysis is less sound is in relation to the likelihood of the implementation of their policy suggestions. Both groups of theorists show some
optimism concerning the capacity of governments to address health
disadvantage through income redistribution and the pursuit of policies which
improve living and working conditions for those at the bottom of the socio-
economic hierarchy. Psychosocial theorists see that improved socio-economic
equity is a rational policy goal because it makes for a more functional society
and is in the interest of business enterprises; neo-materialists argue that political
pressure and rational argument can used to persuade governments to 'tax the
rich and give to the poor' and generally to act in the interests of the health of
socio-economically disadvantaged people.

However, this optimism would appear to be misplaced. In recent years
governments in affluent countries have not tended to implement wide ranging
socio-economic equity measures, to promote health or for any other reason.
Chapter 4 showed that concentrating on the need for macro level policies is
actually unlikely to lead to successful outcomes of any sort. Not, in this case,
because such policies would be ineffective, but rather because in the present
economic and political context it is improbable they will be implemented. It was
argued that in order to understand what policy approaches to health
disadvantage are feasible, that there needs to be recognition of the:

- contemporary causes of socio-economic disadvantage, and
- political discourses that sustain socio-economic inequity.

9.2.3 The deeper causes

Chapter 4 used the concept of social exclusion to explain the processes by which
approximately the lowest quartile of income earners become disadvantaged and
excluded from full social and economic participation. The purpose of this
chapter was to explore the deeper causes of socio-economic disadvantage, and
hence health disadvantage; and also to investigate what relationship location
9. Discussion and conclusions

has with the generation of socio-economic disadvantage. It was argued that understanding these issues would demonstrate what approaches would be necessary to really address the causes of health disadvantage and would also identify what political and structural barriers exist to implementing such approaches. The chapter therefore enabled an evaluation of the positions of the health inequalities researchers which were discussed in Chapter 3 (see above).

Social exclusion describes the social stratum which includes people who earn low incomes, are unemployed, are sole parents and who do not have secure jobs. These people have limited opportunities compared to the rest of the population due to low income and/or insufficient provision of subsidised public goods and services. Social exclusion also describes the processes which have created a marginalised population stratum in this present era. It was shown in Chapter 4 that the processes of social exclusion include:

- the global recessions of the 1980s and 1990s
- the decline of manufacturing and blue collar employment in affluent nations
- increasing proportions of sole parent families
- disinvestment in public provided services (e.g. health, education and transport)
- deregulation of labour markets
- reductions in the provisions of the welfare state, and
- hegemony of neo-liberal economic philosophy.
9. Discussion and conclusions

The question was considered as to whether social exclusion was also caused by locational factors. Social exclusion, it was concluded, tends to have a locational patterning due to the workings of the housing market and the location of public housing. These factors have the effect of sorting households by income and so create identifiably rich and poor suburbs. However, the causes of the initial socio-economic disadvantage are largely in the macro realm, as listed above. Having said this, locational factors can compound social exclusion; for instance, through locational disadvantages such as lack of transport, reduced access to job networks, low quality schooling and poor local job opportunities. These issues are returned to below; however, it is quite clear that locational factors do not cause the problem of social exclusion in the first instance.

9.2.4 Barriers to overcoming social exclusion

Chapter 4 also showed that there are substantial barriers to overcoming social exclusion, and hence to reducing socio-economic and health disadvantage. Some of the factors underlying inequality are those over which governments have little control, such as past recessions, the movement of blue collar jobs offshore and the substantial growth in affluent countries of numbers of sole parent families (who are mostly poor). Other factors are more clearly under government control: governments can choose the extent to which they provide social and economic support for the more vulnerable members of society and can also protect wages and job security.

It was explained in Chapter 4 that over recent decades the adherence to neo-liberalist ideology by many governments, including Australian governments, has exacerbated socio-economic inequality. Neo-liberalism is an ideology which emphasises the importance of economic competitiveness, individualism and of minimising the role of the state. It is associated with policies which encourage competitive labour markets, declining job security and reductions in welfare
safety nets. The observation has been made that countries who have implemented the most intensely neo-liberal policies have ended up with the largest gaps between upper and lower socio-economic groups.

It is apparent that the Australian government [at time of writing] has economic and social policies which are strongly influenced by neo-liberalism. Therefore, one of the conclusions that can be drawn from the discussion in Chapter 4 is that the Australian government is unlikely to implement the policies seen by health inequalities researchers as necessary to reduce health disadvantage; i.e. effective, holistic income redistribution and socio-economic equity policies. In fact, the Australian government [at time of writing] may be expected to implement policies which will eventually exacerbate health disadvantage.

9.3 What can a locational approach achieve?

The first part of the thesis established that a locational approach cannot address the fundamental causes of health disadvantage. In view of this limitation, the second part of the thesis examined what impact a locational approach could be expected to have. It was argued that this question is important given that Australian and other governments are unlikely to do what is really necessary to address health disadvantage – it is therefore worthwhile to examine the potential of more limited solutions.

In examining the possible impact of a locational approach on health disadvantage, the following issues were considered:

- whether locational factors contribute directly to health disadvantage
- the relationship between the socio-economic determinants of health and location in Australia
9. Discussion and conclusions

- the role of public housing estates in concentrating disadvantage
- the potential population reach of a locational approach
- the potential effectiveness of locational approaches/policies/interventions in reducing aspects of socio-economic disadvantage and health, and
- what challenges and possibilities are experienced by those working within disadvantaged locations.

9.3.1 The relationship between disadvantaged location and health

Chapter 5 examined the relationship between disadvantaged locations and health. The reason for examining this link is that adopting a locational approach to address health disadvantage implies that there is such a relationship: namely, that either the health disadvantaged are concentrated in particular locations or there are some characteristics of disadvantaged locations which can damage people's health, or both. Clearly if neither of these relationships can be observed, the justification to intervene at a locational level would appear to diminish, except perhaps as a logistical device.

Chapter 5 found that whilst there is clearly a relationship between location and health, this is almost entirely compositional. That is, the location/health relationship observed in affluent nations largely reflects the individual characteristics of the population who live there, rather than being a consequence of the location itself (i.e. contextual). By definition, compositional effects are a reflection of the concentration of low income earners (and hence health disadvantaged) in particular locations. Contextual effects on health have been observed but are consistently modest. Thus, for example, although it might be expected that living in run down crime prone neighbourhoods would
9. Discussion and conclusions

independently affect health, there is only evidence for quite small independent health effects from living in such neighbourhoods (even in fairly dire locations). Also problematic, when it comes to making practical use of such observations, is that it is almost impossible to isolate what composes these small locational effects – the multitude of factors of which they are comprised are difficult if not impossible to determine.

The discussion of Chapter 5 leads to the conclusion that disadvantaged locations do not create a sufficiently large additional burden on health to, in itself, justify intervening locationally. What this means is that interventions aimed at fixing up and improving deficit locations to reduce the adverse impact of a location on health (including measures such as urban renewal, crime elimination or social capital creation) can, at optimum (i.e. assuming they work as intended) make a minimal difference to the health of people residing in those locations.

Having said this, there are other possibly justifications for a locational approach that emerged in Chapter 5. The concentration of health disadvantaged people in particular areas may justify a locational approach in the sense of targeting services and interventions for these people. Also, it is possible that the socio-economic determinants of health could be partially addressed at a locational level, that is, it may be possible to improve socio-economic well being (and hence health) through a locational approach. These issues were explored in Chapters 6, 7 and 8.

9.3.2 The locational patterning of the socio-economic determinants of health

The purpose of Chapter 6 was to determine if there is a rationale for intervening locationally in Australian cities to reduce health disadvantage. Specifically, this involved examining how and why the socio-economic determinants of health
Discussion and conclusions

are patterned by location in Australian cities. It was intended that this would show the extent to which socio-economic disadvantage, and hence health disadvantage, in Australia could potentially be alleviated by locational interventions and what proportion of the health disadvantaged population would benefit from a locational approach.

The findings of this chapter demonstrated that the socio-economic determinants of health are clearly patterned by location in urban Australia, with each city having identifiably richer and poorer locations. The spatial income segregation that does exist in Australia results from the interaction between unemployment, low incomes, the operation of property markets and public housing policies. These factors and processes sort people into different locations on the basis of income, with higher rents and property prices making some locations less accessible to low income households. In Australia, the creation of highly disadvantaged locations is almost entirely a result of historic policies to build large tracts of public housing for lower paid workers, combined with a subsequent policy change to restrict tenancy to welfare recipients; few current residents of public housing are in the paid workforce.

The issue of public housing is returned to below. In general, locational factors do not have a large effect on creating socio-economic disadvantage in Australian cities. As with health disadvantage, socio-economic disadvantage at a locational level is largely due to compositional factors. Even so, Chapter 6 observed two possible justifications for intervening at a locational level to alleviate socio-economic disadvantage. Some locations do suffer what is termed 'locational disadvantage': disadvantages specific to a location such as poorer quality or overburdened schools, inadequate transport and few local job opportunities. These locational disadvantages compound the effects of socio-economic disadvantage. It was also shown in Chapter 6 that high rates of young sole
9. Discussion and conclusions

parenthood and unemployment in a location may be related to one another – so addressing unemployment could also reduce young sole parenthood.

It can be concluded from Chapter 6 that there is a case that health disadvantage could be reduced by intervening to reduce locational disadvantage and locational hot spots of unemployment. Such measures are justified given that socio-economic disadvantage, and unemployment and sole parenthood in particular, are the factors which underlie health disadvantage. However, given the complexity involved, it is not yet possible to determine the likely ultimate impact on health of such interventions.

9.3.3 The role of public housing

In Chapter 6 it was noted that in Australia locational interventions to improve social and economic outcomes have largely focused on public housing estates. Any geography of disadvantage consistently reveals these locations as the most socio-economically disadvantaged in Australian cities. This suggests that they may be a useful site for interventions to address health disadvantage, both directly and through addressing the socio-economic determinants of health. Undoubtedly many of these areas suffer a host of problems which give a strong justification for interventions. However, when it comes to addressing the more fundamental socio-economic determinants of health, such as unemployment or low income, public housing estates create a number of obstacles.

Chapter 6 showed that residency in public housing is a 'welfare trap', in that gaining employment not only means loss of benefits but also that a person is no longer eligible for subsidised housing and must pay market rent for their public housing, or even leave public housing all together. Thus, residency in public housing creates a substantial disincentive to employment.
9. Discussion and conclusions

In fact high levels of unemployment and worklessness (e.g. among sole parents) can never be reduced in Australian public housing estates under existing welfare and public housing policies. People who get full time jobs will most rationally leave these estates, leaving levels of worklessness unchanged. It is possible that other problems can be addressed on these estates, but two of the major socio-economic determinants of health – low income and unemployment – cannot. Evidence for this conclusion was also apparent in Mt Druitt – the case study showed that the socio-economic of the public housing parts of this area had not changed in decades, and, in fact, there was a perception that disadvantage had become more severe and complex over time (i.e. residents had more complex problems than in the past).

Chapter 6 also showed another problem with focusing interventions in public housing estates: most socio-economically disadvantaged people will miss the potential benefits as public housing only caters for a small proportion of eligible tenants. In addition, socio-economically disadvantaged people living in public housing have advantages over those in private tenancy. Public housing tenants pay lower rents, do not suffer housing stress (paying over 30% of their income in housing costs) and have far more secure housing. In these terms, residents of public housing are not in fact the most disadvantaged people in a city.

It can be concluded from Chapter 6 that while public housing estates may be the most visible forms of disadvantage, there are limitations to what can be achieved by focusing solely on these locations.

9.3.4 Potential population reach of a locational approach

Chapter 6 also examined in detail how socio-economic disadvantage is concentrated in Australian cites generally, not just in public housing estates. The reason for exploring this issue is that underlying a locational approach to
9. Discussion and conclusions

address health disadvantage is the assumption that socio-economically disadvantaged people (and so health disadvantaged) live in identifiable locations implying that concentrating efforts in these locations will reach at least a substantial number of this target population. In Chapter 6 it was found that there is a degree of spatial concentration of socio-economic disadvantage in Australia (as observed by the fact that there are richer and poorer suburbs), but it is far from total. It was demonstrated that Australian low income households are not confined to a limited number of suburbs and are to be found in varying proportions across the suburbs of a city.

A secondary analysis of Census 2001 was conducted to explore the issue of spatial segregation by income. The data was from Sydney, the Australian city with the highest level of socio-economic inequity. The concentration of low income households in low income suburbs was measured according to three different household income thresholds ($400, $500 and $600/week). The percentage of households in each suburb for each income threshold was determined. A disadvantaged suburb was defined as containing one third or greater households under the selected income threshold. What this study found was that, even when using quite generous household income cutoffs, the vast majority of low income households do not live in suburbs where a third or more of other residents are also low income earners. For example, in Sydney more than 70% of low income households (as defined by household income of $500/week or less) are located outside disadvantaged suburbs (as defined by a one third or greater concentration of low income households).

The finding that suburban income segregation is limited follows that made in other countries, including the US, where income segregation is actually far more severe. The analysis also showed that public housing is the main factor
9. Discussion and conclusions

concentrating socio-economic disadvantage, with the ten poorest suburbs having between 32% and 92% public housing.

It can be concluded from Chapter 6 that any locational approach, except on a very large scale (say, across much of Western Sydney), will inevitably miss large sections of the health disadvantaged population.

9.3.5 What can locational policies and interventions achieve?

Chapter 7 explored the question of what locational interventions can be expected to achieve, given the many limitations found in the prior chapters of the thesis. The chapter examined whether a locational approach for a limited sector of the population, could potentially:

- address some of the factors which cause social exclusion (e.g. unemployment and poverty)
- ameliorate the effects of socio-economic disadvantage on health (e.g. through providing extra health services or early intervention programs).

The first part of Chapter 7 discussed the outcomes of locational approaches directed to addressing unemployment and poverty in Europe and the United States. In Western Europe in particular, there has been a shift by governments towards using locational approaches to alleviate social and economic problems, sometimes involving multimillion dollar expenditure packages over many years. Chapter 7 found that the international experience of the effectiveness of these approaches is one of failure – they are unable to resolve the paradox of poor populations in affluent nations. These interventions can at best move problems to other locations, but can never remedy them. This conclusion was consistent with that of Chapter 4, that social exclusion and the associated states
9. Discussion and conclusions

of unemployment, job insecurity and poverty are caused by macro socio-economic factors.
9. Discussion and conclusions

The second part of Chapter 7 considered the potential ameliorative impact on health disadvantage of four locational policies:

- health equity spending (allocating more health resources)
- early intervention (support for young children and families)
- social mix (changing the income mix of households in a location), and
- social capital creation (building community links and cohesion).

These policies were selected to be examined because they have all been implemented in Australia and in other nations. If they are demonstrably, or potentially effective, then there is a case that they be recommended to be used in disadvantaged locations to benefit the resident population.

9.3.5.1 Health equity spending

It was found that offering increased and better quality health services to residents of disadvantaged locations is potentially an effective measure. Chapter 2 showed that there is evidence that providing quality health services can reduce health disadvantage. Given the greater burden of poor health suffered by socio-economically disadvantaged people it is also equitable that they be allocated more resources (the principle of vertical equity). However, the question of whether increasing health resources, in general, and/or at a location level, will reduce health disadvantage in Australia requires more research. There is a pressing need to clearly determine what positive impact health services can make on reducing health disadvantage, looking at issues of both quantity and quality of services.
9. Discussion and conclusions

9.3.5.2  *Social mix*

Social mix involves reducing the density of low income households in disadvantaged locations through increasing the numbers of higher income households. This policy appears to hold theoretical indirect benefits to health through reducing some of the impacts of socio-economic disadvantage in a location. For instance, some of the expected benefits of social mix to socio-economically disadvantaged people include providing greater access to job networks, improved provision of services, improving social capital and reducing the social stigma of a location. However, at this point the only established benefit of creating social mix is a reduction in social stigma for particular locations. It is important to note that the possible benefits from social mix may take many years to become apparent.

9.3.5.3  *Social capital*

It has been asserted that generating social capital in a location (e.g. building social support networks and improving social integration) is a measure that is both cheap and likely to benefit health. However, many questions remain about social capital. It was shown in Chapter 2 that at a collective level the asserted links between social capital and health are unproven; it cannot be shown that reduced collective social capital (such as overall levels of trust) leads to poorer health outcomes across a population. Therefore, there is no evidence to justify improving collective social capital in particular locations in order to improve health.

The exact relationship between social capital and health disadvantage at an individual level is still not clear. Although it has been shown that increased social capital for an individual can buffer their health against the effects of socio-economic disadvantage, it cannot be said definitively that a lack of social capital
9. Discussion and conclusions

itself contributes to health disadvantage (i.e. the poorer health of socio-economically disadvantaged people). Reduced social capital may in fact be a symptom of low income, rather than part of the causal links between low income and poorer health. The issue is further complicated by great imprecision as to what social capital actually is, the relationship of social capital to location (as opposed to between locations, within families or work places, for instance) and serious questions about whether social capital can in fact be created and/or sustained.

The complexity of social capital was illustrated in the Mt Druitt case study. Here, it was apparent that there were strong friendship, family and community bonds between people – in many instances these bonds provided support and companionship, but in other instances were actually counterproductive, in terms of facilitating criminal behaviours and/or substance abuse. In addition, many individuals had little contact with working people and employment networks and culture. Thus, if social capital were to be ‘generated’ in Mt Druitt, the question arises whether this would be best achieved by supporting relationships within the community or seeking to support links with organizations and individuals outside the community.

Overall, for all the intense excitement generated by social capital in the health inequalities literature, many questions remain as to its effectiveness as a practical measure to improve health in disadvantaged locations.

9.3.5.4 Early intervention

The most unexpected finding of the research was the very modest impact of early intervention in improving social, educational or economic outcomes. This finding was unexpected because intervening in the early years of life appears a logical measure to reduce the likelihood of later socio-economic and health
disadvantage. However, the research literature reveals a different story. With the exception of a handful of high cost intensive programs, interventions such as home visiting, support for young families and preschool programs have been found to produce very small or no long term beneficial changes for participants. Even the results of the very expensive long term 'model' programs, whilst more impressive (and often cited), do not bring disadvantaged children on par with their middle class peers.

The implication of the findings about early life interventions, discussed in Chapter 7, is that most early intervention programs running in urban Australia can be expected to have only a very small impact in reducing socio-economic and health disadvantage.

9.3.6 Challenges at the grassroots

The case study of Mt Druitt, discussed in Chapter 8, highlighted the enormous amount of energy and commitment that can be generated within disadvantaged locations in attempts to reduce socio-economic and health disadvantage. There was evidence that locational interventions can make small and possibly important differences to the residents of disadvantaged locations; for instance, through providing breakfast to children, setting up additional targeted services, and improving literacy. It showed that there is evidence of a widespread commitment by agencies and workers in this disadvantaged location to work to address the causes and effects of socio-economic disadvantage. Thus, in this case, it is not a lack of commitment by agencies or grass roots enthusiasm that impedes locational interventions. In addition, the study illustrated how disadvantaged locations can serve to attract additional resources to local services and residents, even if in service of other external agendas (e.g. crime reduction).
9. Discussion and conclusions

Whilst recognising the success that can happen within a disadvantaged location, the case study also showed that there are substantial barriers to working effectively to reduce disadvantage at a locational level. At an organisational level, operational factors such as work demands, staffing, resourcing and limited funding cycles limit what can be achieved. Also, given the demands on organisations, many were by necessity more focused on meeting the immediate needs of residents rather than intervening to prevent or reduce disadvantage. There are also many factors related to socio-economic disadvantage that are beyond the control of people working within locations, such as: unemployment, lack of transport, public housing tenancy policies, and the location of alcohol and gaming facilities.

It is also apparent that even pressing needs for particular services are not necessarily going to be met; for example, state government departments or private enterprise do not have to respond to the pleas of local residents, councils or organisations. The failure to improve bus services or provide adequate food access in some suburbs of Mt Druitt illustrates this problem.

Also of interest was the fact that although there was a wide diversity of projects running in Mt Druitt at the time of the study, these projects were mostly short term initiatives aimed at specific target groups. Given that health disadvantage is the consequence of long duration socio-economic disadvantage, projects which are limited in time and scope clearly cannot be expected to have more than a very minor effect on eventual health outcomes. The observations in Mt Druitt also reflect the critiques of a locational approach to social exclusion outside Australia (raised in Chapter 7): it is not actually possible for multiple small location based interventions to address deeper structural inequalities. And, whilst it should not detract from the extraordinary efforts of people
9. Discussion and conclusions

working in places like Mt Druitt, in isolation or as a whole these location based interventions cannot create enduring socio-economic improvement.

9.4 Contribution of this thesis

The main contribution this thesis makes to knowledge is the demonstration of the limitations of a locational approach to reduce the problem of health disadvantage in urban Australia. This thesis shows that if an Australian government or other agency is interested in reducing health disadvantage across the population, a locational approach can only contribute modestly to that outcome.

In theoretical terms, the thesis develops an original synthesis of knowledge from a range of disciplines. Thus, although some of the findings within the thesis are not original (e.g. the limited population reach of a locationally targeted approach), the manner in which the knowledge was approached and applied to the question of health disadvantage is original. That is, no other researcher has taken this particular span of literature and research and applied it to the question of the potential effectiveness of a locational approach to reduce health disadvantage.

The two small original studies contained within the thesis also constitute original contributions to knowledge: specifically, the quantitative study of the spatial distribution of low income households in Sydney (Chapter 6) and the qualitative case study of Mt Druitt (Chapter 8). The first study identified suburbs with high concentrations of low income households and showed the degree to which households are concentrated by income in Sydney suburbs. This involved a secondary analysis of ABS data – an analysis that has not been undertaken, to the knowledge of the author, by any other researcher. The study also provided an estimated population reach of a locational approach to address
9. Discussion and conclusions

health disadvantage in urban Australia. This estimate has also not, in the knowledge of the author, been determined by any other researcher.

The second qualitative study was original in the first place by virtue of being a case study with a unique set of interviewees and questions. Studying the challenges of intervening in disadvantaged locations is not in itself original; however, what was original was the application of the findings to a discussion of the potential of a locational approach to address health disadvantage.
9. Discussion and conclusions

The thesis also further developed a number of positions (or arguments) which had already been stated by other researchers (mostly quite briefly). These positions are:

- it is necessary to incorporate political and economic context into research on health disadvantage
- it is important to recognise the population coverage of a locational approach to health disadvantage (i.e. to determine how many health disadvantaged people it will reach)
- the limited achievements of locational interventions to date in promoting socio-economic equity need to be recognised, and
- further explorations into the independent contextual effect of location on health disadvantage may not be of any great practical value.

Finally, a new position was developed concerning the relationship between public housing estates and socio-economic and health disadvantage. It was shown that, although these estates will predictably be the focus of 'helping efforts' due to the concentrated disadvantage they contain, there are inherent limits to what can be achieved in these locations (see above).

9.5 Limitations of this thesis

The scale and scope of the research involved in this thesis brought with them a number of limitations. Taking a wide cross disciplinary approach to a problem almost inevitably results in the omission of some finer detail and complexities. This limitation was exacerbated by the need to critically examine large amounts of research, including a great deal that was exploring new and even contested ideas. Thus, although it seems unlikely that an improved evidence base might
9. Discussion and conclusions

have resulted in different overall conclusions, the possibility exists that findings along the way could have varied or been more precise; for example, when the longer term impacts of interventions emerge, such as changing social mix.

Social theory was incorporated into the research (indeed it was argued that this was essential), but a more intensely theoretical treatment of the question could have been undertaken. This could have involved positioning the research question within a well developed theoretical analysis of social and economic inequality and uneven economic and spatial development under capitalism. As it was, the thesis focused more on the contemporary manifestations and processes of social and economic inequality, rather than on highly developed theoretical explanations for why they exist.

The content of the thesis was also limited by a lack of data and the small number of locational interventions that have been implemented or evaluated. Ideally, there would have been a wide range of substantially funded, robustly evaluated Australian interventions to discuss. As there was not, it was necessary to draw from overseas data and to discuss some interventions in a fairly speculative way: for example, the possible impact of health services. The possibility exists that better funded location based efforts may produce more effective results than the interventions that were considered. That is, although the main argument concerning the limitations of a locational approach stands, locational interventions themselves may have greater potential to produce change than this research was able to determine.

One area in particular suffered from a lack of data. It was suggested that when it comes to contextual factors, health might actually be affected more by factors which impact on socio-economic disadvantage as compared to factors which directly affect health. For example, 'locational disadvantages' such as poor
9. Discussion and conclusions

quality schools and lack of job opportunities could have a greater impact on health (by dint of diminishing income or contributing to local unemployment) than more directly health related factors such as pollution or excessive numbers of fast food outlets. Not enough is known currently about the effects of context on socio-economic disadvantage to explore this issue fully. Thus, although it could be posited that health would benefit from the provision of better services, schools and opportunities in all locations, whether or not such measures will actually lead to reduced health disadvantage cannot yet be ascertained.

Four different types of locational interventions were examined. Clearly a number of other locational interventions could have also been discussed, in particular efforts to change health behaviours at a locational level. The examples used in the thesis were designed to be illustrative of some of the possibilities and limitations of locational interventions, and specifically to show that beliefs about 'what works' are sometimes based on paltry evidence. Health behaviours were not discussed, despite forming a large part of the burden of health disadvantage. This omission was because these health behaviours are so multifaceted (including eating, smoking, drinking, sleeping and exercise) and operate in such complex ways, that a short within chapter section could not cover the necessary detail. Having said this, a detailed discussion of the effectiveness of locational interventions in addressing health behaviours could contribute further to this area of research.

The case study in Chapter 8 illustrated some of the issues confronting people working in disadvantaged locations; the limitation of this research, as a case study, is that it is not possible to generalise from the experiences in this location to other locations.
9. Discussion and conclusions

9.6 Conclusion: where to now for a locational approach to reducing health disadvantage?

This thesis has shown that the real problem with health disadvantage is not so much explaining what causes it but doing what is necessary to reduce it. Although the quest to reduce health disadvantage may make socialists or liberals out of the most unlikely people, the reality is that the problem is firmly located within a capitalist economic system – a system which generates socio-economic inequity and social exclusion. In countries such as Australia, a dominant neo-liberal discourse places a seemingly immovable political barrier to reducing the inevitable systemic inequities. This suggests that, for the time being at least, it is necessary to accept limited possibilities and to ask ‘what is the best that can be done within the existing system?’ In fact it could be argued that, in order to avoid misplaced optimism, all possible solutions to the problem of health disadvantage should be framed by this question.

This thesis considered one solution to the problem of health disadvantage – a locational approach. It is concluded that such an approach can only have a minimal impact on the problem of health disadvantage. Despite this limitation, it is apparent that intervening locationally is an attractive option for government and government agencies to take in order to attempt to reduce health disadvantage or socio-economic disadvantage. In coming years it could reasonably be expected that the locational focus will ‘take off’ in Australia, as it has in the United Kingdom, particularly within public housing estates and identifiable pockets of disadvantage. The motivations for governments taking this approach may not be that important – whether it is, as some have suggested, a cynical ‘disguising of what is really necessary to solve the problem of health disadvantage’, or whether it is all that is pragmatically possible – what
is important is that agencies pursuing intervention on a locational basis maximize the effectiveness of their efforts.

When it comes to being as effective as possible within the limitations of disadvantaged locations, a number of points can be made as to potential future directions. The tendency for researchers to dismiss health services as an important factor in understanding health inequalities was discussed in Chapter 2. Indeed it could be said that the whole health inequalities discourse contains an implied refutation of the view that 'health is about health services'. However, in the scheme of things, health services is one area that health departments can readily influence, and they can do so far more effectively than the areas of employment, education, early intervention, social capital, or even health behaviours. Also, there is a strong case for vertical equity – to provide more health services to those who need them most. This could mean improving access to quality health services for people resident in disadvantaged locations, including mental health, allied health and dental health services.

On the other hand, although health departments have a limited range of influence, the complexity of the problem of health disadvantage creates partnering possibilities. The fact that health disadvantage is really a problem of socio-economic disadvantage and social exclusion means that there are many potential partners with whom health departments might engage. It would seem that, as in the United Kingdom, partnering across agencies to improve socio-economic well being would be a useful course of action to address health disadvantage. Thus it might be hoped that disadvantaged locations would be provided not only with high quality health services but also the best available intervention programs, numerous new employment opportunities, and would have schools, transport, and amenities at least the equal of those in other locations in a city. The result of such measures could be that, in the words of
9. Discussion and conclusions

British Prime Minister Tony Blair, 'no one need be further disadvantaged by where they live'. Such measures can, of course, never resolve health disadvantage across a national population, but they may be expected to somewhat reduce the depth of health and socio-economic disparity for the minority of people confined to identifiably disadvantaged locations.

Furthermore, locational interventions may help prevent the further physical and socio-economic deterioration of particular locations, through, for example, infrastructure improvements and provision of educational and employment opportunities.

This research was not generally concerned with the outcomes of individual locational interventions because the focus of the thesis was whether intervening locationally *per se* represented a useful course of action to reduce health disadvantage. Having said this, once one accepts an aim of reducing health disadvantage it is clearly inadequate to provide interventions or extra services and amenities simply in the hope that they will make a difference. It is important to critically examine the evidence as to what interventions or elements of interventions have been effective and to rigorously evaluate new interventions. It is also necessary to avoid inflating the significance of those interventions which have, in reality, achieved only modest results.

Finally, it is necessary to acknowledge and honour the work of people who work in disadvantaged locations. Their efforts to improve the lives of the poor and excluded take place under the burden of great challenges and little recognition. It is not the intention of this thesis to in any way diminish the value of the 'bearing of witness to struggle' or of grassroots efforts to reduce socio-economic disadvantage and health disadvantage.
9. Discussion and conclusions

References
9. Discussion and conclusions


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342
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9. Discussion and conclusions


350
9. Discussion and conclusions


9. Discussion and conclusions

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