PORTLAND
DISTRICT HEALTH

2013

Social Connection and Equity in Health

Prepared by Bridget King
Health Promotion Officer
Portland District Health
June 18 2013

Contents

Acknowledgements

Thank you to everyone who offered their help and support throughout the development of this paper:

- Rowena Wylie – Project Officer, Southern Grampians and Glenelg Primary Care Partnership
- Lynda Smith – Health Promotion Officer, Portland District Health
- Hayley Dunning – Youth Development Officer, Glenelg Shire Council
- David Towl – Health Promotion Officer, RMIT University
- All agencies and individuals who took part in the stakeholder consultations and who offered their time, advice and knowledge

Executive Summary

Portland District Health (PDH) and Southern Grampians Glenelg Primary Care Partnership (SGGPCP) have partnered to produce briefing papers on social connection and equity in health (focusing on disadvantaged populations) to support the planning process associated with the 2013-2017 Municipal Public Health and Wellbeing Plan (MPHWP) for the municipalities of Glenelg and Southern Grampians.

This paper concentrates on the Shire of Glenelg, providing an overview of social connection and equity in health, with the understanding that SGGPCP will develop a corresponding briefing paper concentrating on the Southern Grampians Shire. Based on the research undertaken, particularly the stakeholder consultations, this paper provides a summary on the current social health issues facing disadvantaged population groups and suggestions on what actions the whole community can take to address them.

Health inequities are the disparities in health between social groups with different levels of social disadvantage (Braveman & Gruskin 2003). Social disadvantage or advantage refers to those attributes (eg. wealth and power) that define how people are grouped in social hierarchies (Braveman & Gruskin 2003). For governments, particularly local government, enhancing social capital can be relatively inexpensive and straightforward by encouraging social interaction at a local level (Bryson & Mowbray 2005). 'The role for government in generating social capital is to create the opportunities for individuals to establish relationships and shared values; that is, to facilitate the creation of networks. The site for network creation is the local community, and community strengthening is the means to do so' (Blacher cited in Bryson & Mowbray 2005).

Wilkinson (2006) describes social vulnerability and inequality as '…the connection between individual psychosocial risk factors and our sensitivity both to the immediate social environment and to the broader social structure of modern societies'. As this is such a wide encompassing determinant, Wilkinson (2006) has identified three psychosocial risk factors as being the most important; social status, social affiliations and stress in early

life. While it is important to acknowledge there are many sources of stress, Wilkinson (2006) contends that social status, social support/affiliations and early life are the most powerful sources of stress, having the biggest impact on population health. These risk factors encapsulate the meaning of the term 'social connection', providing a defined context within such a diverse and comprehensive theme. Based on these understandings of health, the Health Promotion Unit at Portland District Health recommends that the social determinants of health, particularly social connectivity, equity and early years should be used as an overarching theme throughout the Glenelg Municipal Public Health and Wellbeing Plan for 2013-2017.

Key findings

- Evidence shows lack of/limited social capital can negatively impact health and wellbeing outcomes
- Glenelg Shire has the highest rate of disadvantage in the Great South Coast and should therefore be at the forefront of all local government planning and development decision making (across all sectors, not just health)
- Inequities in health are widespread across Australia – in Glenelg particularly, this is more profound and heightened for people living with a disability and Aboriginal and Torres Strait Islander people
- Interventions to improve health that focus on people who are already ill can have a negative/minimal impact because they do not address the factors that cause the problem

Recommendations for Glenelg Shire Council

- Always consider and use the social model of health and the social determinants of health when planning and developing priorities and policies for the Glenelg MPHWP
- Social connectivity, equity and early years be used as an overarching theme throughout the Glenelg MPHWP 2013-2017
- Consider social capital and social support as highly critical in improving community health and wellbeing
- Conduct a needs assessment/social capital community survey to measure what assets the community already has, what needs to happen and how existing assets can be utilised to increase social capital and address the social determinants of health
- Always consider disadvantaged populations when developing policies and strategies to improve community health and wellbeing
- Always use a range of top-down (public policy and advocacy) and bottom-up (Individual personal development) approaches with a focus on community empowerment and engagement, rights, equity, education, public policy and advocacy when planning strategies and approaches in action plans
- Provide ongoing encouragement and support to improve partnerships and intersectoral collaboration

Background

Introduction

For governments, particularly local government, enhancing social capital can be relatively inexpensive and straightforward by encouraging social interaction at a local level (Bryson & Mowbray 2005). 'The role for government in generating social capital is to create the opportunities for individuals to establish relationships

and shared values; that is, to facilitate the creation of networks. The site for network creation is the local community, and community strengthening is the means to do so' (Blacher cited in Bryson & Mowbray 2005).

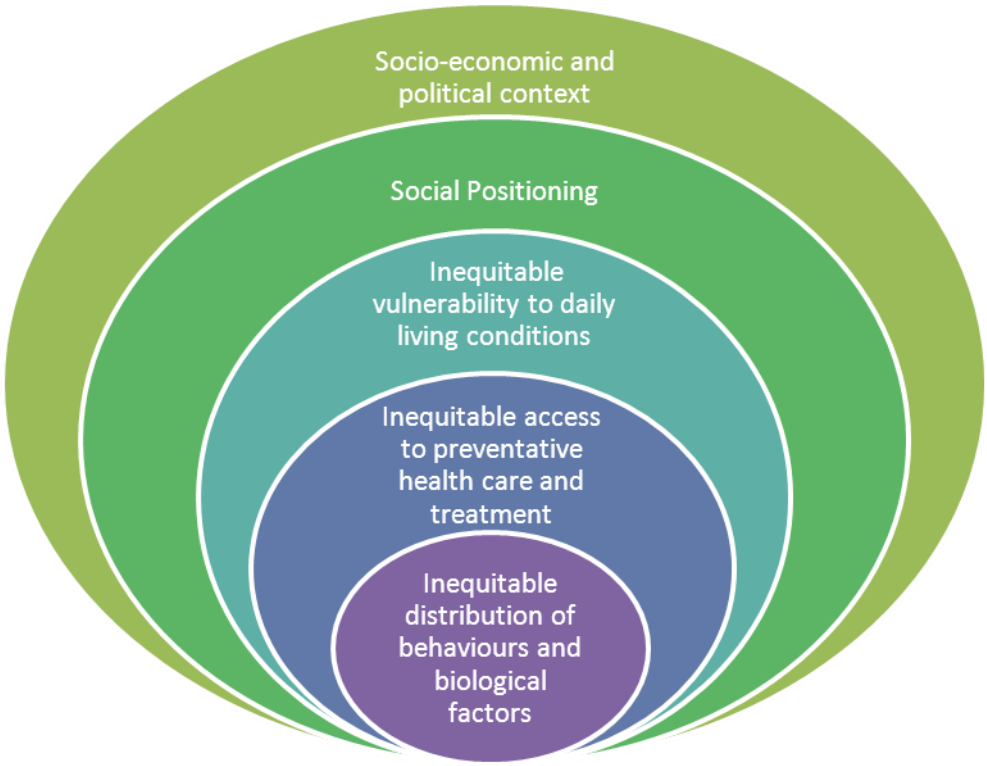
The recently released Great South Coast Health and Wellbeing Profile (2013) revealed high levels of disadvantage throughout South West Victoria, particularly Glenelg. Residents in Glenelg are significantly worse off in multiple areas including; life expectancy, income and preventable diseases, compared to the Victorian state average. Many of the factors that influence these issues can be related to poor social capital, thus by increasing levels of social capital, the community is likely to experience greater happiness and educational attainment, higher income and ultimately live longer, healthier lives (Bryson & Mowbray 2005).

Portland District Health and Southern Grampians Glenelg Primary Care Partnership have partnered to produce briefing papers on Social Connection and Equity in Health (focusing on disadvantaged populations) within the municipalities of Glenelg and Southern Grampians. This paper concentrates on the Shire of Glenelg, providing an overview of social connection and equity in health, with the understanding that SGGPCP will develop a corresponding briefing paper concentrating on the Southern Grampians Shire. It is hoped that this paper will guide and support the development of the Municipal Public Health and Wellbeing Plans for the 2013-2017 planning cycle. This paper explores the current social health issues facing disadvantaged population groups through stakeholder consultations, data collection and evidence-based policy and research.

Social inequities and disadvantage can encompass multiple health issues such as high income disparities and poor life expectancy, thus in order to understand the causes of these differences and to take action to address them, a social determinants of health approach needs to be taken (Marmot 2006). As the term 'social connection' is quite broad, this paper focuses on improving social capital, equity and 'social vulnerability' as a key social determinant of health. Wilkinson (2006) contends that social vulnerability has 'a major impact on population health', as large proportions of the population are exposed to the hazards of poor social status, weak social affiliations and stress in early life.

Developed from a health promotion perspective; (health promotion being defined by Nutbeam (cited in Keleher 2007) as: a comprehensive social and political process which embraces actions focused on strengthening the skills and capabilities of individuals and changing social, environmental and economic conditions to alleviate their impact on public health) in other words, health promotion is about enabling people to take control of the factors that affect their health (Keleher 2007). In order to successfully achieve this, community based agencies need to utilise a range of top-down (public policy and advocacy) bottom-up (Individual personal development) approaches, with a focus on rights, empowerment and equity (Keleher 2007).

Figure 1 The Social determinants of health inequities: the layers of influence (based on VicHealth draft framework 2013)



Healthy citizens and communities can only be achieved by taking action on the social determinants of health in order to obtain greater health outcomes (Keleher, MacDougall & Murphy 2007). The social determinants of health are the conditions in which people are born, grow, live, work and age, shaped by the distribution of money, power and resources at global, national and local levels (World Health Organisation 2013a). In essence, this relates to the unjust and avoidable differences in health status within and between countries, communities and individuals (WHO 2013a).

Socially unjust differences in health encapsulate health inequities; those disparities in health between social groups with different levels of social disadvantage (Braveman & Gruskin 2003). Social disadvantage or advantage refers to those attributes (eg. wealth and power) that define how people are grouped in social hierarchies (Braveman & Gruskin 2003). Advantaged or disadvantaged social groups include socio-economic status (income, assets, occupational class and education level), ethnic or religious groups and those groups defined by gender, geography, age, disability or sexual orientation (Braveman & Gruskin 2003).

Despite Australia's generally high standards of health, inequities in health are widespread across the country (Macdonald 2010). These inequities are particularly profound for people living in relative socio-economic disadvantage (see Figure 1.6), people living with a disability (WHO 2012) and Aboriginal and Torres Strait

Islander people, illustrating the need to address the social determinants that affect the health inequities in disadvantaged populations (Macdonald 2010). For the purposes of this paper, disability is defined as; 'one or more of 17 limitations, restrictions or impairments which have lasted or are likely to last, for a period of six months or more, and which restrict a person's everyday activities' (Australian Institute of Health and Welfare 2013).

The health status of a population can be improved equally as much by addressing those factors in the social environment that impact health and social inequities, as it is by investing in medical technology (Macdonald 2010). If Glenelg Shire Council accepts the evidence that increasing social capital will ultimately improve overall health and wellbeing within the community, it is imperative that a range of top-down and bottom-up approaches are utilised to effectively address those health issues (Keleher, MacDougall & Murphy 2007). Keleher, MacDougall and Murphy (2007) contend that it is also equally important to always consider and integrate the basic principles of health promotion when planning, implementing and evaluating initiatives to address public health issues (See Figure 2).

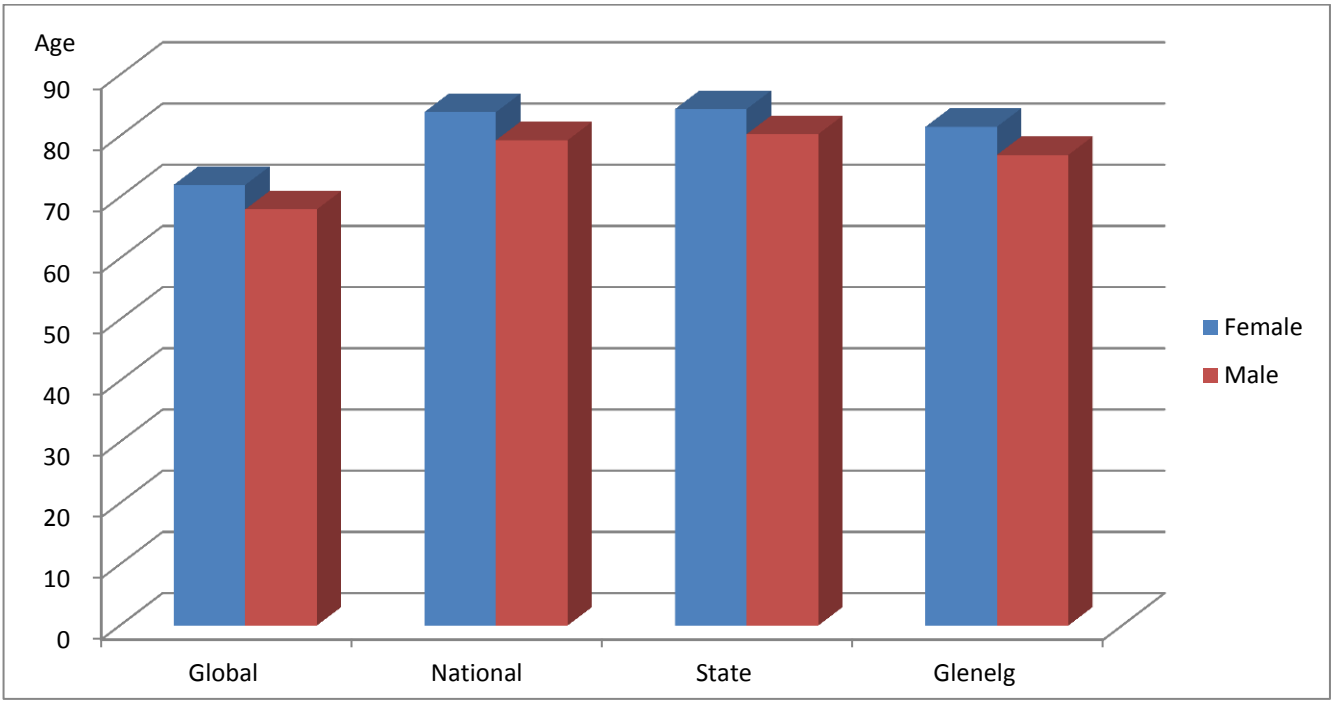
Figure 2 Health Promotion Principles (Source: Keleher, MacDougall and Murphy 2007)

Setting the scene

There have been many well planned health promotion and prevention policies which have made enormous contributions to improving public health and wellbeing (National Preventative Health Taskforce 2009). In recent years, preventative strategies targeting serious public health issues such as; smoking, road accidents and HIV/AIDS, have been successful in reducing the prevalence of poor health outcomes (National Preventative Health Taskforce 2009). While these are great examples of successful health promotion strategies, preventable health problems continue to cripple countries, communities and individuals throughout the world. It is for this reason that governments, agencies, health practitioners and the wider community need to identify and holistically address the social determinants behind particular preventable health and wellbeing issues (Marmot 2006). For example, people who are in a low socio-economic position have higher rates of smoking than those in high socio-economic positions (Marmot 2006). The social determinants relating to this issue are variable and could encompass (but not limited to): social gradient, early life, unemployment, social support and cohesion, poverty and social exclusion, education and social vulnerability and inequality (Marmot 2006).

Interventions to improve health by encouraging the population to change their lifestyles and behaviours can have a negative or minimal impact for varied reasons, but often because they focus on the outcome (those who are already ill) and do not address the factors that cause the problem (Robertson, Brunner & Sheiham 2006). People who are socially disadvantaged generally experience poor working and living conditions, have limited or no social support, reduced educational opportunities and food insecurity (WHO 2013b). They are more likely to have poorer access to health services and high rates of ill-health and early mortality, compared to those in privileged social positions (WHO 2013b). Thus Glenelg Shire Council should always consider the social determinants that affect and lead to poor health outcomes, particularly when focusing on disadvantaged populations.

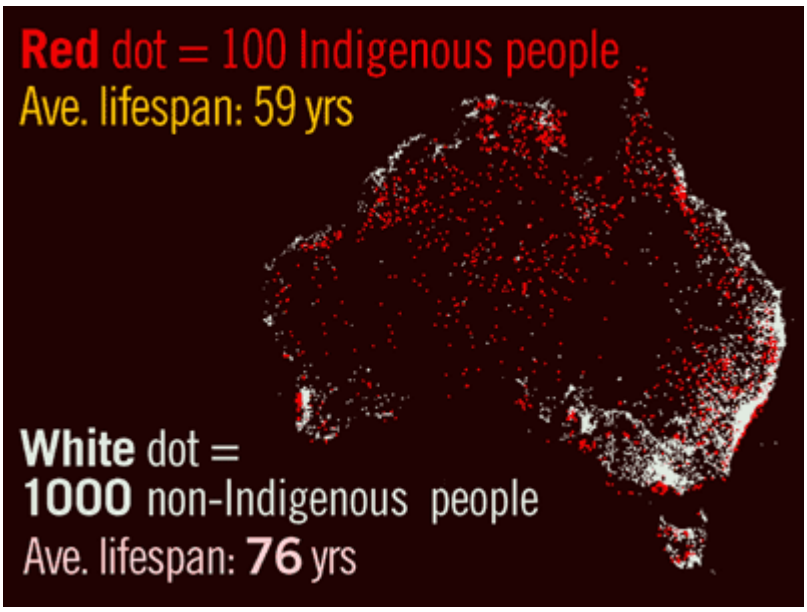
Figure 3 Life Expectancy – years from birth (Source: Great South Coast Health and Wellbeing Profile 2013)



Although there are many contributing factors that affect life expectancy, evidence shows that low income countries have significantly lower life expectancy compared with high income countries (Wadsworth & Butterworth 2006). In 2001, the life expectancy for low income countries was 59 years from birth, while for high income countries the average age was 78 (Wadsworth & Butterworth 2006). While the life expectancy for both men and women in Glenelg is significantly higher than the global average, it is still considerably lower than the Australian and Victorian average figures (see figure 3).

It is also important to note the differences in life expectancy between Aboriginal and Torres Strait Islanders and non-Aboriginal people in Australia. According to ABS (2012) data, in 2005-2007, the life expectancy at birth for Aboriginal and Torres Strait Islander males was 67.2 years, 11.5 years less than that for non-Indigenous males (78.7 years). For Aboriginal and Torres Strait Islander females, life expectancy at birth was 72.9 years, 9.7 years less than for non-Indigenous females (ABS 2012). A higher incidence of diabetes, ear and eye diseases, respiratory disorders and higher infant mortality rates can be attributed to the lower life expectancy experienced by Aboriginal and Torres Strait Islander Australians (ABS 2012). This is particularly significant for the Glenelg Shire as 2.16% of the population are Aboriginal and Torres Strait Islanders, while the overall population of Indigenous people in Victoria is 0.74% (Department of Health 2013). Unfortunately, figures for the life expectancy of Aboriginal and Torres Strait Islanders living in Glenelg are currently unavailable (Great South Coast Health and Wellbeing Profile 2013). The image below (Figure 4) depicts the inequitable difference between Indigenous and non-Indigenous Australian's life expectancy.

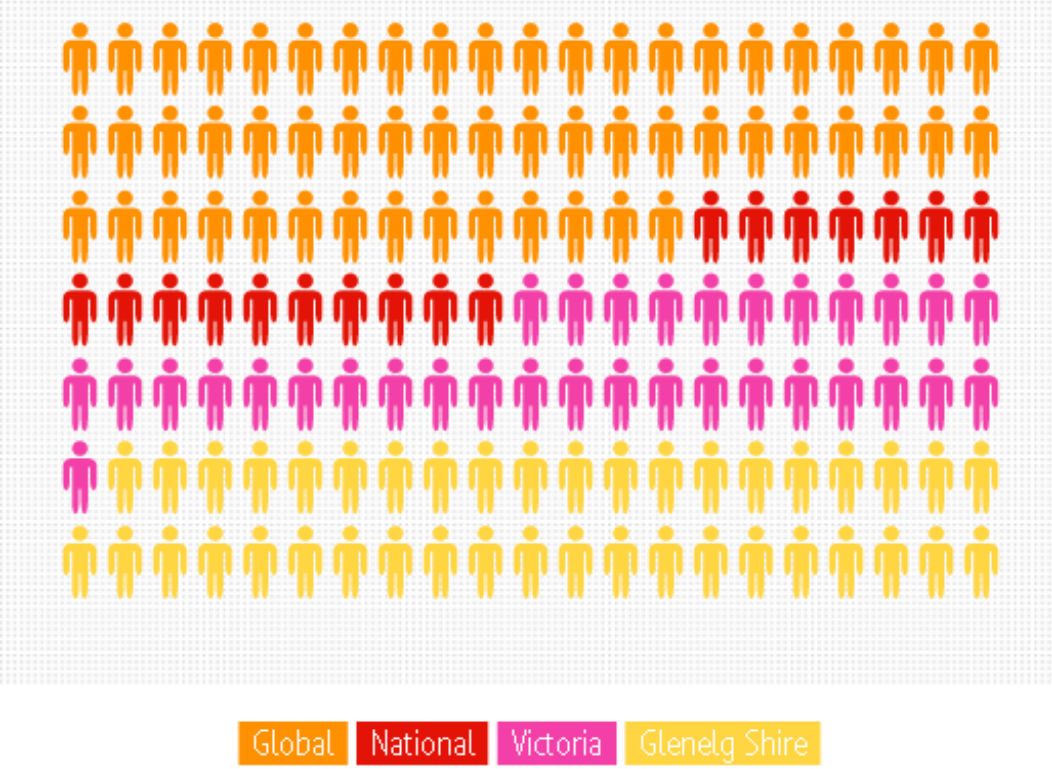
Figure 4 Life expectancy for Indigenous and non-Indigenous Australians (Source: Creative Spirits 2012)



The above figures are indicative of the current social discrepancies and inequities affecting the health and wellbeing of disadvantaged populations. Furthermore, people living with a disability are much more likely to be disadvantaged and have unmet health needs than people living without a disability (WHO 2012). According to the ABS 2011 Census (2012), people living with disability have a much lower median income ($323 per week) compared to people without a disability ($613 per week) and are mostly employed part-time. The most common occupations for people with a disability are unskilled or low skill positions such as; factory process workers and cleaners (ABS 2012).

Figure 5 shows the profound affect disability has on countries, communities and individuals throughout the world. In comparison with the national and state figures, Glenelg has a larger population of people with a disability with 6.3% needing assistance with core activities and 4.6% having a severe and profound disability (Department of Health 2013). Personal and social networks for people with a disability are particularly important in order to support their participation and involvement in the wider community, thus enhancing their well-being and the social capital of the community (ABS 2011a).

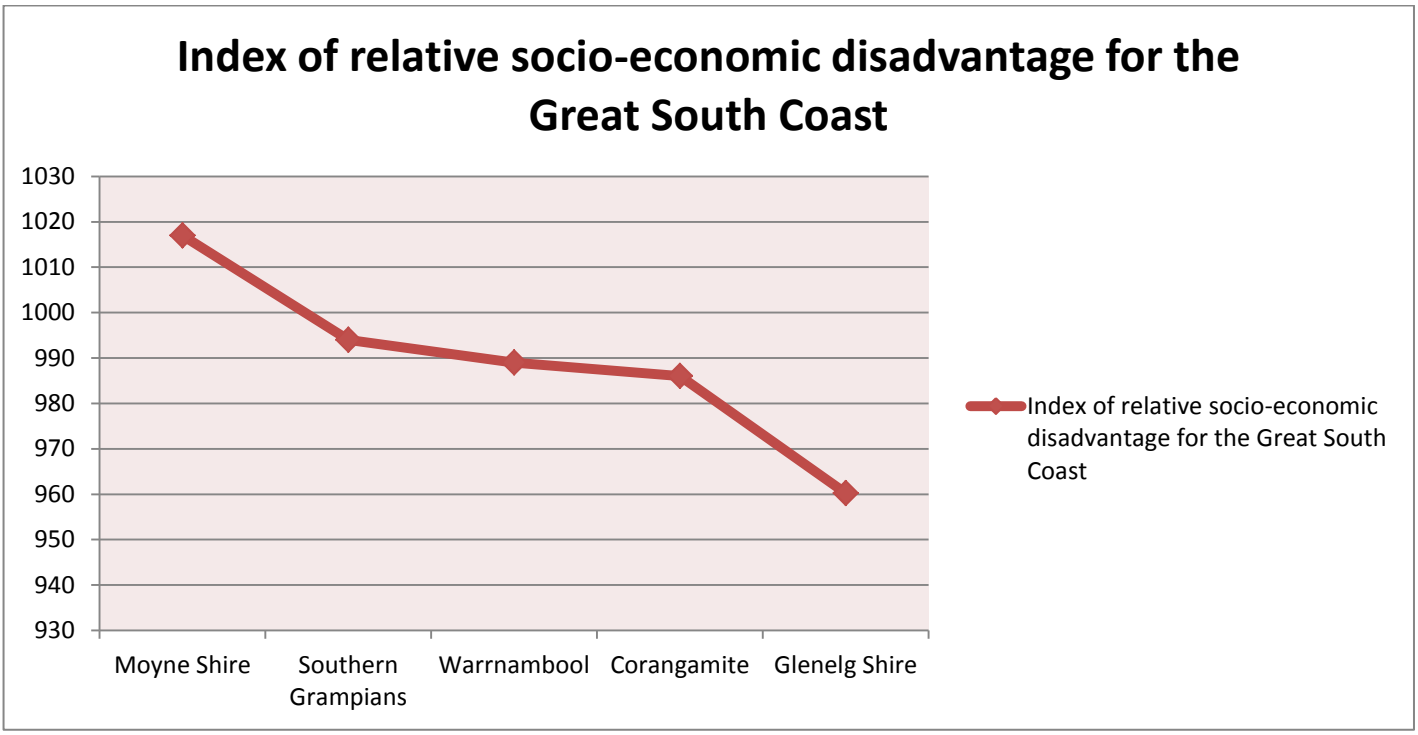
Figure 5 Percentage of people with a disability (Sources from: WHO, ABS and Department of Health)



The recently released Index of relative socio-economic disadvantage (IRSED) data from the Australian Bureau of Statistics (ABS 2013) revealed that Glenelg is the 19th most disadvantaged Local Government Area (LGA) out of the 79 LGAs in Victoria. The IRSED rates municipalities around Australia by measuring the relative level of socio-economic disadvantage based on a range of factors including: low income, low educational attainment, high unemployment, and jobs in relatively unskilled occupations (Profile.id 2013). LGAs that rate well in these areas receive a higher score for example; the Shire of Nillumbik is the least disadvantaged LGA in Victoria scoring 1098.3, while Greater Dandenong in Melbourne's east is the most disadvantaged scoring a low 894.9 (Profile.id 2013).

Figure 6 (on page 11) represents the inequitable disparities between the five shires within the Great South Coast. Glenelg is clearly the most disadvantaged LGA, while Moyne is the most advantaged. In analysing Glenelg's disadvantage by area, the most disadvantaged suburb was Portland (Central) scoring 933.3, the most advantaged being Casterton with 966 (Profile.id 2013).While this data may appear to show some areas within Glenelg as more advantaged than others, the highest scoring area (Casterton) is still much more disadvantaged compared to the other four Shires in the GSC (as shown in Figure 6).

Figure 6 Index of relative socio-economic disadvantage for the Great South Coast (Source: ABS 2013)



The health levels of the most privileged reflect levels that are biologically attainable, thus providing the minimum standards for what should be possible for everyone in any given society (Braveman & Gruskin 2003). The notion of equal opportunities to be healthy is fundamental to equity in health and refers to the highest possible level of physical and mental wellbeing (Braveman & Gruskin 2003).

The above data demonstrates the need to always consider and focus on disadvantaged populations and groups when planning, implementing and evaluating health promotion interventions, policy change or advocacy. Glenelg in particular is a very disadvantaged LGA area, and should therefore be at the forefront of all planning and development decision making (health, town planning and infrastructure, early years/youth, transport etc), particularly for the Great South Coast region. Moreover, effective action at the local community level requires intersectoral collaboration and strong partnerships, looking towards the long-term in order to have the greatest health outcomes for those highly disadvantaged groups (Hunter, Neiger & West 2011).

Evidence

As the terms social vulnerability, disadvantage and inequities are quite broad and varied in meaning, it is important to note that there are many different terms used to describe these issues. While the main focus is on social connection; social status, social affiliations and early life, other terms such as ‘social capital’, ‘social

support', 'income inequality' and 'social cohesion' were used to find a range of appropriate evidence-based literature.

The importance of social support, health outcomes and community engagement has advanced the agenda for taking a social determinants approach to health promotion, and lead to a greater focus on the concept of social capital (Fleming & Parker 2007). Social capital correlates with social vulnerability and inequity, in that it focuses on strengthening social support and cohesion within communities (Fleming & Parker 2007). Within the context of this paper, social cohesion refers to a collective community-level characteristic measured by the levels of trust, norms of reciprocity and the formation of strong social bonds within the local community (Fone et al. 2007).

A study on whether social cohesion effects the association between area income deprivation and mental health discovered that income deprivation and social cohesion were significantly associated with poor mental health (Fone et al. 2007). Based on the UK definition of poverty, area income deprivation is defined as the percentage of households in each district with a gross household income of less than £10,000 per annum (Fone et al. 2007). The results of the study suggest that the effect of deprivation is significantly reduced in areas of high social cohesion and is greater in areas of low social cohesion (Fone et al. 2007). Fone et al. (2007) found that this effect was only evident at the community-level, not when focused on individuals alone. These results indicate that in areas of disadvantage, high levels of community social cohesion based on friendships, visiting, borrowing and exchange of favours with neighbours is potentially of great importance in protecting mental health (Fone et al. 2007).

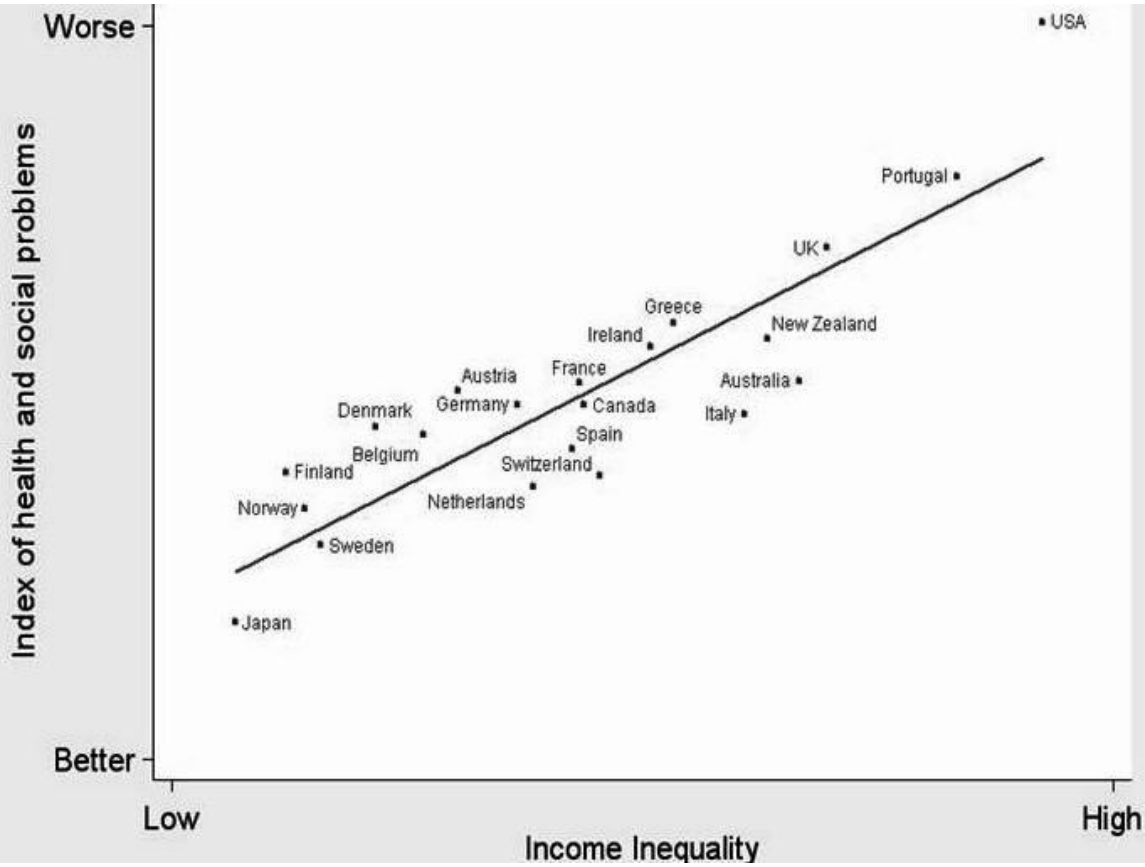
Putnam (cited in Fleming & Parker 2007) argues that increasing social ties, opportunities and human connections will increase community participation and ultimately, improve population health outcomes. Social connections are created through various avenues, one of the most common being the workplace (ABS 2006). An Australian Bureau of Statistics report (2006) identified the value of workplace relationships, explaining that they can facilitate the development of friendships and contacts with broader sources of information and connections through encounters with a wide range of colleagues, clients and other work associates. The workplace was noted by Putnam (cited in ABS 2006) as being a valuable setting in providing opportunities to work collaboratively in a team, form a sense of community among co-workers, as a source of friendships and a place to build norms and reciprocity.

Social networks are also drawn upon when looking for work (ABS 2006). As explained by Stone, Gray and Hughes (cited in ABS 2006), family and friends are often relied on as sources of information when searching for paid

work, whereas professional contacts are more likely to be accessed by people already in paid work. Comparatively, long-term unemployment can reduce the number of social ties of an individual, which may lead to social exclusion and a decline in community participation, thus reducing social capital (ABS 2006).

A study conducted in the US on the connection between social capital, income inequality and mortality found that income inequality was strongly correlated with both group membership and lack of social trust (Kawachi et al. 1997). Low rates of social trust and group membership were both associated with total mortality and death rates from coronary heart disease, malignant neoplasms (tumours) and infant mortality (Kawachi et al. 1997). The report ultimately concluded that the growing gap between the rich and the poor has led to a decline in social cohesion and trust, the direct result of a disinvestment in social capital (Kawachi et al. 1997). Therefore, based on the findings by Kawachi et al. (1997), investment in social capital should ultimately increase social trust, social affiliations and number of group memberships and in turn, decrease rates of mortality, coronary heart disease and cancer.

Figure 7 Income inequality and index of health and social problems internationally (Source: Wilkinson & Pickett 2009)



The above figure shows that as the level of income inequality increases, the number of health and social problems also greatly increases, creating a steeper social gradient and a greater divide in social status (Wilkinson & Pickett 2009). Therefore, the practice of enhancing social capital as a platform for addressing the social

determinants of health may be more relevant for countries such as Australia that have a high gradient and high income inequality (Hunter, Neiger & West 2011). Although current evidence shows the most effective health promotion initiatives in improving health outcomes are implemented and evaluated over a long time frame, changes in social capital and health can be achieved in a relatively short period of time (Hunter, Neiger & West 2011).

Increasing social capital can improve outcomes for Glenelg Shire, making social capital initiatives more appealing to term-oriented policy makers, where traditional interventions might not produce discernible outcomes for many years (Hunter, Neiger & West 2011). Thus appropriately designed policies have the ability to reduce health disparities without necessarily redistributing income, as long as it focuses on lower income and disadvantaged populations and provides opportunities to build social capital in the community through increased social connections, trust and reciprocity (Hunter, Neiger & West 2011).

Social and health policy context

Figure 8 Public Health plans, reports and policies that impact health promotion

International

The World Health Organisation is the directing and coordinating authority for health within the United Nations system (WHO 2013b). It is responsible for providing leadership on global health matters, shaping the health

research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends (WHO 2013b). According to WHO (2013b), health is a shared responsibility, involving equitable access to essential care and collective defence against transnational threats.

The Commission on Social Determinants of Health (CSDH) was established by the World Health Organisation in 2005 to support countries and global health partners in addressing the social health factors leading to ill health and health inequities (WHO 2013c). The aim of The Commission was to draw the attention of governments and society to the social determinants of health and in creating better social conditions for health, particularly among the most vulnerable and disadvantaged people (WHO 2013c). The Commission delivered its report to the World Health Organisation in July 2008 and it has subsequently ended its functions (WHO 2013c).

National

The Australian Health Promotion Association (AHPA) is the only professional association in Australia specifically for people interested or involved in the practice, research and study of health promotion (AHPA 2013). The health promotion profession has evolved alongside, and in response to, the international health promotion movement (driven heavily by the WHO) and the broader new public health movement (AHPA 2013). Health promotion not only embraces actions directed at strengthening the skills and capabilities of individuals but also actions directed towards changing social, economic, political and ecological conditions to reduce their impact on population and individual health (AHPA 2013).

State

The Victorian Public Health and Wellbeing Plan 2011-2015 (VPHWP) aims to: 'improve the health and wellbeing of all Victorians by engaging communities in prevention, and by strengthening systems for health protection, health promotion and preventative healthcare across all sectors and levels of government' (Department of Health 2011). VPHWP plans to take a focus on disadvantaged populations and have a' strong emphasis on the needs of higher risk and vulnerable population groups' and 'tailor interventions for priority populations to reduce disparities in health outcomes' (Department of Health 2011).

Regional and Local

As outlined by the Municipal Association of Victoria (2012), the VicHealth Indicators survey (2011) and the Victorian Government's Victorian Population Health Survey (VPHS) are two of the main data sources available to support the development of the MPHWP 2013-2017. As well as the recently released Great South Coast Health and Wellbeing Profile 2013, these data sets 'enable local government planners to gain a comprehensive picture

of health and wellbeing in Victoria' and within specific local government areas (MAV 2012). Local governments play a key role in promoting and improving public health and wellbeing within the community. By applying a range of strategies that address the social determinants of health, council can greatly contribute to the improvement of social connections and economic opportunities, thus improving population health outcomes and the overall health of the community (VicHealth 2012).

Figure 9 The Great South Coast Regional Strategic plan's identified common themes (Source: Regional Development Australia & Regional Development Victoria 2012)

The Great South Coast Regional Strategic Plan (Regional Development Australia & Regional Development Victoria 2012) developed and agreed upon by participating advisory members including both the Southern Grampians Shire Council and Glenelg Shire Council, identifies five pillars in which strategic direction and planning is focused at a regional level. Figure 9 (above) provides a snapshot of the identified challenges for each strategic pillar developed by The Great South Coast Group. Social connection and inequities in health has the potential to

be incorporated and addressed across all five strategic pillars and as such, should be integrated across all priority areas within the MPHWP.

To assist in the development of the MPHWP, VicHealth has produced a series of local government action guides, which outline recent research and ideas for local action on particular social health issues including: reducing health inequalities, increasing social connections and improving Aboriginal health and wellbeing (VicHealth 2012). The recommended strategies outlined in the guides align with national, state and local health promotion priorities, including The Victorian Public Health and Wellbeing Plan 2011-2015 (VicHealth 2012). These action guides should be considered in the development of the MPHWP and other community plans and strategies in order to adequately address the social health issues within the municipality.

Stakeholder consultations

A limited number of consultations (due to time constraints) with key stakeholders in Glenelg were conducted by Portland District Health and Southern Grampians and Glenelg Primary Care Partnership. Stakeholders were asked a serious of questions including: what does and doesn't work in our community, the key issues and social determinants affecting health and wellbeing in Glenelg and possible actions and future capacity to address those identified issues. Interviews were mostly conducted in person and some were conducted via email. Consultation responses are summarised in the table below (page 18), outlining the key themes, key stakeholders involved, link to GSC priorities and actions for consideration based on stakeholder recommendations and evidence-based research.

The social determinants of health (factors that cause social health issues)	*Social support and cohesion *Social capital *Early life & education *Social vulnerability & inequality *The social gradient and the life course	*Food *Transport *Poverty & social inclusion *Ethnic/racial inequities *Neighbourhoods & housing	* Health & the psychosocial environment at work * Sexual health * Employment & job security *Social organisation & stress *Elderly people		
Key themes	**What works in our community**	**What doesn't work in our community**	**Key Stakeholders**	**Links to Council Priorities**	**Actions for consideration (Evidence-based)**
Social connectivity & disadvantaged groups - Single-parent families - Indigenous peoples -Disability - Minority groups - Low SES - Low literacy	Community consultation & social inclusion Strong partnerships & networks Commit to using social capital as a way of reducing health inequities Building rapport with community Strong communication & advocacy Community empowerment & capacity building	Making decisions without community & stakeholder consultation Short-term approaches or one-off programs Ad-hoc/last minute advertising Exclusion of disadvantaged groups	Local government State government Regional groups (eg. Great South Coast Group) Health agencies Education sector Indigenous services Community groups Emergency services	Early years & young people Accessibility & transport Community resilience Drugs/ alcohol & gambling	1. Explicit policy statements on health equity in all Council documents and plans (eg. Community engagement strategy) 2. Creation of safe play & socially inclusive areas 3. Work closely with Indigenous services to improve cultural awareness & knowledge (eg. Aboriginal Partnership Plan expand to offer training for community services) 4. Encourage & promote neighbourhood connections (eg. partner with local shops to donate food vouchers for neighbourhood & street parties & events) 5. Promote & demonstrate leadership in community volunteering (as pathways to employment) 6. Invest in the future through planned on-going programs rather than short term 'projectism'

Key Themes	What works	What doesn't work	Key stakeholders	Link to GSC priorities	Actions for consideration
Funding & sustainability	Strong partnerships & networks Advocacy Building trust with the community Strong communication & community empowerment	Inequitable allocation of resources Short-term funding Inequitable focus on downstream funding (personal development)	State government Local government Regional groups Community & philanthropic groups Local businesses Community & private organisations	Social connectivity & active living Early years & young people Accessibility & transport Community resilience Drugs/ alcohol & gambling	1. Promote & develop understanding across sectors of social determinants of health 2. Clearly identify with partners the levels at which interventions should be targeted: advocating for long-term health gains (using existing evidence) 3. Link small and manageable local initiatives into coherent programs through coordinated planning 4. Integrate programs across sectors to avoid the 'silo' effect (eg. equitable funding spread across services & partnership brokerage)
Access & transport	Community consultation & advocacy Strong partnerships & networks Easily accessible & affordable public transport Better coordinated services & PT	Unreliable & ill-planned public transport Poor access to bulk billing GPs & limited outreach services Lack of coordination between services High transport costs Lack of free/available shelter & activities	Local government State government Community & private organisations Regional groups Community & philanthropic groups	Social connectivity & active living Early years & young people Community resilience Drugs/ alcohol & gambling	1. Advocate for improved public transport - better coordination & accessibility, more frequent & affordable (eg. TAFE access) 2. Build strong partnerships with health services for improved service coordination & collaboration 3. Advocate for increased outreach services 4. Use outcome of transport needs assessment to inform policy making 5. Provide & lobby for equitable sporting, arts & cultural groups/clubs

Key Themes	What works	What doesn't work	Key stakeholders	Link to GSC priorities	Actions for consideration
Education: - Literacy - Educational attainment & engagement - School readiness - Health literacy & sexual health - Family support	Develop trust & respect Having good support and strong partnerships Providing calm & safe environments Strong community relationships Building strong, trusting relationships with families Greater transition back into mainstream education & employment (TAFE, work skills)	Lack of sustainable funding (short-term) Working in silos (not in partnerships) Poor child & family support Lack of adequate public transport Lack of alternative education opportunities (outside mainstream)	Local government State government Regional groups Health agencies Education sector Indigenous services Community groups Emergency services Local businesses	Social connectivity & active living Early years & young people Accessibility & transport Community resilience Drugs/ alcohol & gambling	1. GSC could register and promote (to other agencies) the Healthy Together Achievement Program as a health promoting workplace 2. Conduct needs analysis for early years/youth (eg. youth engagement and inclusion) 3. Plan for youth controlled & engagement strategies based on needs analysis 4. Strong focus on early years and family engagement in education & literacy 5. Design policies & interventions using what is known about models of effective practice 6. Support & promote affordable adult literacy & education (eg. transitioning into/back into workforce – Centrelink) 7. Continue to build strong partnerships with education sector and families– focusing on youth re-engagement & positive role modelling (eg. expanding Standing Tall mentoring program) 8. Use digital media as platform to promote and provide educational opportunities

Key Themes	What works	What doesn't work	Key stakeholders	Link to GSC priorities	Actions for consideration
Mental health & wellbeing: - Low self-esteem & lack of confidence - Vulnerable & lack assertiveness - At risk of family/sexual violence & abuse - Stigma - At risk of homelessness - Young people	Consistency Liaising with other agencies & strong partnerships Following through on promises Building trust with community Continued social support Being open & honest Be supportive and available Creating achievable goals Building coping & resilience skills (improving self-efficacy)	Lack of communication between agencies (loss of trust & rapport) High turnover of staff Too many processes (red tape) Lack of access to services Availability of agencies and their outreach (eg. financial counselling) Lack of control (poor self-efficacy) One-off 'sessions' (ticking a box) Being forced to participate	Local government State government Health agencies Education sector Community & philanthropic groups Regional groups	Social connectivity & active living Early years & young people Accessibility & transport Community resilience Drugs/alcohol & gambling	1. Long-term & equitable distribution of funding across health services 2. Lobby for single bed (social) housing 3. Increased funding for family services (limited family oriented services, could increase outreach) 4. Increase in school focused youth services 5. Improve digital & social media connections with community (particularly youth) 6. Increase staff (particularly in youth sector) 7. Engage local people in developing positive strategies as a priority - take time and care to ensure that involvement is democratic and relationships are respectful (as part of a socially inclusion community)

Key Themes	What works	What doesn't work	Key stakeholders	Link to GSC priorities	Actions for consideration
Food security & oral health - Access & availability of affordable, nutritious food & drink - Stigma & judgement - Early years & youth	Social support & positive reinforcement Supported play groups (as platform for promoting good nutrition & oral health) Strong family support & incentives to participate Early learning transition into schools Long-term, ongoing supportive initiatives Upstream funding Linking with other services & social connectedness	Lack of collaboration & coordination between services Lack of control (poor self-efficacy) Poor accessibility to affordable services High turn-over of staff/gaps in system High stress, lack of social & family support Low health literacy = ↑consumption energy dense food & drink Energy dense food advertising (targeted at early years & youth)	Local government State government Regional groups Health & community agencies Education sector Indigenous services Community groups Emergency services Local businesses	Social connectivity & active living Early years & young people Accessibility & transport Community resilience Drugs/alcohol & gambling	1. Support development of oral health initiatives targeting Aboriginal communities (eg. Deadly Teeth) 2. Promote & encourage involvement with community garden (as safe & socially inclusive) 3. Implement healthy food and drink policies in early years, educational & workplace settings 4. Advocate for reduction/abolition of unhealthy food/drink advertising targeted at children 5. Partner with community agencies to implement healthy eating policies in workplaces and children's settings (including sporting venues) 6. Improve training for health services to effectively serve & treat people with special needs (across all sectors) & cultural sensitivity training 7. Continual promotion of healthy food & drink consumption (eg. edible gardens, walkways & streets in public areas) 8. Encourage & promote Farmer's Markets (collaborate with key partners to hold regular markets in accessible areas)

Recommendations

- Always consider and use the social model of health and the social determinants of health when planning and developing priorities & policies for MPHWP

- Consider social capital and social support as highly critical in improving community health and wellbeing

- Conduct a needs assessment/social capital community survey to measure what assets the community already has, what needs to happen and how existing assets can be utilised to increase social capital and address social determinants of health

- Always consider disadvantaged populations when developing policies and strategies to improve community health and wellbeing

- Always use range of top-down (public policy and advocacy) and bottom-up (Individual personal development) approaches with a focus on community empowerment and engagement, rights, equity, education, public policy and advocacy when planning strategies and approaches in action plans

- Provide ongoing encouragement and support to improve partnerships and intersectoral collaboration

Limitations

This briefing paper was produced with the intent of providing a snapshot of the unjust and inequitable disparities in health, particularly profound for disadvantaged populations. As Social Connection and Equity in Health is such a broad topic, all aspects of social connectivity and disadvantaged populations could not be covered to its fullest possible extent.

Having a short time frame (and also not having a specific due date) to conduct a needs analysis, limited the capacity to produce a fully comprehensive briefing paper. Due to time restrictions, not all appropriate agencies were able to be consulted, some organisations were also unable to be contacted. Therefore the summary of the stakeholder consultations (Page 18) is not a complete picture of all agencies in the Glenelg region. The parameters of the project restricted capacity to conduct community consultations, as well as lack of time and resources. However, Glenelg Shire Council has since produced postcards asking for feedback from the community and also conducted several community consultation workshops in Glenelg. Community feedback should be reflected in the Municipal Public Health and Wellbeing Plan 2013-2017.

Bibliography

Alexander, R 2013, personal interview, Dhauwurd-Wurrung Elderly & Community Health Service, Portland, 24 May.

Anderson, M 2013, personal interview, Loaves & Fishes, Portland, 6 May.

Austin, C 2013, personal interview, Glenelg Shire Council, Portland, 6 May.

Australian Bureau of Statistics 2006, 'Aspects of Social Capital, Australia, 200', retrieved 27 May 2013, <http://www.ausstats.abs.gov.au/Ausstats/subscriber.nsf/0/DAD0CFD697AE9B25CA2571AD0082E1C6/$File/49110_2006%20(Reissue).pdf>.

Australian Bureau of Statistics 2011, 'Life Expectancy Trends – Australia', retrieved 19 April 2013, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features10Mar+2011>.

Australian Bureau of Statistics 2011a, 'Social Participation of People with a Disability, 2011', retrieved 11 June 2013, <http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4439.0Main%20Features22011?opendocument&tabname=Summary&prodno=4439.0&issue=2011&num=&view=>.

Australian Bureau of Statistics 2012, 'Gender Indicators, Australia, Jan 2012', retrieved 19 April 2013, <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by+Subject/4125.0~Jan+2012~Main+Features~Life+expectancy~3110>

Australian Institute of Health and Welfare 2013, 'Definition of disability', retrieved 11 June 2013, <http://www.aihw.gov.au/definition-of-disability/>.

Braveman, P & Gruskin, S 2003, 'Defining equity in health', Journal of Epidemiol Community Health, vol. 57, pp.254-258, retrieved 27 March 2013, Academic Search Elite.

Bryson, L & Mowbray, M 2005, 'More spray on solution: community, social capital and evidence based practice', Australian Journal of Social Issues, vol. 40, no. 1, pp. 91-106.

Creative Spirits 2012, 'Aboriginal statistic timeline', retrieved 27 June 2013, <http://www.creativespirits.info/aboriginalculture/people/aboriginal-statistic-timeline>.

Department of Health 2011, *Victorian Public Health and Wellbeing Plan 2011-2015*, DoH, Melbourne, Victoria.

Department of Health 2013, '2012 Glenelg area profile', retrieved 11 June 2013, <http://docs.health.vic.gov.au/docs/doc/476F736BB3D44053CA25786600143090/$FILE/Glenelg_2012-v02.pdf>.

Dunning, H 2013, personal interview, Portland District Health, Portland, 16 April.

Fone, D, Dunstan, F, Lloyd, K, Williams, G, Watkins, J & Palmer, S 2007, 'Does social cohesion modify the association between area income deprivation and mental health? A multilevel analysis', International Journal of Epidemiology, vol. 36, pp.338-345, retrieved 27 March 2013, <http://ije.oxfordjournals.org/content/36/2/338.full>.

Hunter, BD, Neiger, B & West, J 2011, 'The importance of addressing social determinants of health at the local level: the case for social capital', Health and Social Care in the community, vol. 19, no. 5, pp.522-530, retrieved 5 June 2013, <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2524.2011.00999.x/pdf>.

Kawachi, I, Kennedy, B P, Lochner, K & Prothrow-Stith, D 1997, 'Social Capital, Income Inequality and Mortality', American Journal of Public Health, vol. 87, no. 9, pp.1491-1498, retrieved 27 March 2013, <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.87.9.1491?keytype2=tf_ipsecsha&ijkey=31ce7e5f00ac1039a3d994743df3d79caa79d132&>.

Kenneally, A 2013, personal interview, Glenelg Shire Council, Portland, 28 May.

Leddin, S 2013, personal interview, Portland District Health, Portland, 16 April.

Macdonald, J J 2010, 'Health Equity and the Social Determinants of Health in Australia', Social Alternatives, vol. 29, no. 2, pp.34-40, retrieved 28 March 2013, Academic Search Elite.

Maybery, J 2013, personal interview, Glenelg Shire Council, Portland, 23 April.

Municipal Association of Victoria 2012, 'Municipal Public Health & Wellbeing Plans', retrieved 11 June 2013, <http://www.mav.asn.au/policy-services/health/Public-health-plans/Pages/default.aspx>.

Nancarrow, F 2013, personal interview, Loaves & Fishes, Portland, 6 May.

Navarro, V & Shi, L 2001, 'The political context of social inequalities and health', Social Science and Medicine, vol. 52, pp.481-491, retrieved 27 March 2013, CINAHL with full text.

Nepean, J 2013, personal interview, Glenelg Shire Council, Portland, 6 May.

Picard-Arnott, K 2013, email, SalvoConnect, Portland, 19 April.

Profile.id 2013 'Glenelg Shire Community Profile', retrieved 19 April 2013, <http://profile.id.com.au/glenelg/seifa-disadvantage?es=2>.

Reefman, N 2013, personal interview, United Way, Portland, 23 April.

Regional Development Australia & Regional Development Victoria 2012, 'The Great South Coast Regional Strategic Plan', retrieved 11 June 2013, <http://www.rdv.vic.gov.au/__data/assets/pdf_file/0006/67839/Great-South-Coast-Regional-Strategic-Plan-Pt1-pp01-11.pdf>.

Robinson, S 2013, personal interview, Brophy Family and Youth Services, Portland, 24 April.

Thomas, C 2013, personal interview, Re-engagement Centre, Portland, 17 May.

Turner, S 2013, personal interview, Brophy Family and Youth Services, Portland, 24 April.

VicHealth 2011, 'VicHealth Indicators Report', retrieved 14 May 2013 <http://www.vichealth.vic.gov.au/Research/VicHealth-Indicators/VicHealth-Indicators-Report.aspx>.

VicHealth 2012, 'VicHealth local government action guides', retrieved 14 May 2013, <http://www.vichealth.vic.gov.au/Publications/VicHealth-General-Publications/VicHealth-local-government-action-guides.aspx>.

VicHealth 2011, 'VicHealth Indicators Survey', retrieved 14 May 2013, <http://www.vichealth.vic.gov.au/Research/VicHealth-Indicators/LGA-Profiles.aspx>.

Wilkinson, R G 2006, 'Ourselves and others – for better or worse: social vulnerability and inequality', in M Marmot & RG Wilkinson (eds), Social Determinants of Health, 2nd edn, Oxford University Press, Oxford, UK, pp. 341-357.

Wilkinson, R & Pickett, K 2009, *The Spirit Level: Why Greater Equality Makes Societies Stronger*, Bloomsbury Press, New York.

World Health Organisation 2012, 'Disability and health', retrieved 11 June 2013, <http://www.who.int/mediacentre/factsheets/fs352/en/index.html>.

World Health Organisation 2013a, 'Social determinants of health', retrieved 19 April 2013, <http://www.who.int/topics/social_determinants/en/>.

World Health Organisation 2013b, 'About WHO', retrieved 13 June 2013, <http://www.who.int/about/en/>.

World Health Organisation 2013c, 'Commission on Social Determinants of Health, 2005-2008', retrieved 13 June 2013, <http://www.who.int/social_determinants/thecommission/en/