Reflections on health equity: why is progress so slow and what else can we do?

Eberhard Wenzel Oration

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I want to begin by paying my respects to the traditional owners of this land – the Eora Peoples of the Gadigal Nation and to elders past and present. More, I want to acknowledge the forty thousand years (or more) of knowledge, experience, and wisdom that they carry – and to reflect on this fact. Aboriginal nations survived where others did not – proving able to adapt to the inevitably changing conditions within which they lived. After reading Jarrod Diamond's book *Collapse* – on the self-inflicted demise of many other societies after much shorter periods – the achievement of our Aboriginal peoples seems even more remarkable.

I want to also make special mention of Eberhard Wenzel who understood this. He was a committed, tireless public health professional, who, with his wife Rosmarie Erben, contributed in uncountable ways to the development of our profession and to working with people who had been pushed to the margins of societies everywhere. Eberhard was fierce and intelligent, and spent his life learning about ways to make the world a fairer, more just place – and passing on that learning through his teaching and research. I am honoured to be speaking in his name – and to be following in the footsteps of some of Australia's great public health researchers, teachers, and practitioners. Thank you for the opportunity.

Health promotion, social justice, and equality

The idea of equality is perhaps the defining feature of modern political thought[1]and is a core principle of the social justice to which most modern western democracies are committed. The concept of social justice is also at the heart of the discipline of health promotion – with priority given to equality as a core value.[2] Health promotion (as a discipline) is committed to ensuring that all people have equal opportunities to access the economic, social, and environmental conditions we need for good health, long fulfilling lives, and wellbeing, and to ensuring that all people have the knowledge, skills, and confidence we need to take up and make the most of the opportunities.

The field has an enormous responsibility - a mandate from government and society to contribute to protecting, promoting and sustaining the health of the population. Over time, its practitioners, researchers, and policy makers have developed technical skills in measurement, planning, implementation, and evaluation; process skills in organising and educating ourselves and others, and in advocating for and facilitating social change; and capacity-building skills to enable the health sector, and organisations in other sectors (including civil society and the private sector) to contribute to improving the health of the population. Through our work with individuals, communities, organisations, governments and policy makers those of us working in the field have contributed to preventing disease, injury, and early death on large scales. As part of the work we've proposed and supported changes in health and public policy and practice – some of them far from what we imagined was possible in the 1980s. We've found ways to work with other sectors – moving beyond 'let's tell them what to do' to working more intelligently and respectfully within partnerships to influence the determinants of health.

Increasingly, we've needed to investigate the moral and ethical underpinnings of our work – and to recognise the significant roles played by the values that we, and others, hold.

Health promotion, though, has not been responsible, alone and directly, for all the policies and actions that governments, civil societies, and markets have taken that have resulted in improvements in the health of populations.

Over the last century multiple public policy decisions contributed to the economic and social development of the nation. A combination of universal enfranchisement, organised labour, decent wages and conditions, responsiveness to market conditions, entrepreneurialism, and expanding (mostly) employment opportunities created a thriving economy. Gradually, we established systems to deliver universal access to essential services – education, health care, and transport infrastructure (for example). We developed a welfare system to support people who were recognised as requiring social assistance to survive (although not, necessarily, thrive). There have also been significant improvements in the quality and delivery of health care across the spectrum of primary, secondary, tertiary, rehabilitative, and palliative care services. New treatment options, new pharmaceutical therapies, and improved service delivery have all contributed to improvements in the health of the population.

Along the way enormous social changes were instituted, arising from different bases – a social movement led to increases in women's participation in and contribution to the public life of the nation; while economic and social (post-war) pressures resulted in a large immigration program that saw Australia taking steps to evolve as a multicultural society. Although many of these initiatives were not intended, explicitly, to improve the health of the population, there is little doubt that their combined effect was positive for the health of the majority of citizens.

As a consequence of all these actions our nation has been very successful in improving the life expectancy of all citizens and in reducing risks to health. By 2010, Australia was ranked fourth in the world for the average life expectancy at birth - having increased our ranking from 10th to 4th in the period 1960 to 2010. See Table 1.

Table 1: World rankings in life expectancy in 1960 and 2010[3]

	1960	Rank	2010	Rank
Japan	67.7 years	35	82.2 years	1
Singapore	63.7 years	45	82.1 years	2
Australia	70.8 years	10	81.7 years	4
Norway	73.6 years	1	80.1 years	13
UK	71.1 years	9	79.9 years	16
USA	69.8 years	16	78.2 years	29
Cuba	64.2 years	43	77.6 years	32
China	36.3 years	162	74.5 years	64
India	42.3 years	135	66.5 years	126

Recognising the problem: seeing what we're looking for

As a population health practitioner I viewed this ranking as one indicator of Australia's success as a nation – a significant achievement. I viewed it as an illustration that it is possible to improve the life expectancy of populations significantly and on a large scale – something of which the nation could be proud.

I did not, though, consider how the same information would be viewed from another perspective. My Aboriginal colleague reviewed the table and quietly asked what Australia's world ranking would be in 2010 if the average Aboriginal and Torres Strait Islander life expectancy was used instead of the whole population average? A return to the ranking table showed that when the average life expectancy of Aboriginal peoples and Torres Strait Islanders is substituted in the calculation of the ranking, Australia's world ranking would be approximately 159th for males and approximately 140th for females.[4]

Moreover, when compared with the indigenous peoples of other, similarly colonised nations Australia's Aboriginal peoples' and Torres Strait Islanders' life expectancy continues to be the lowest.[5]

Table 2: Indigenous and non-Indigenous life expectancies: an international comparison

	Indigenous Males	Indigenous Females	Males – gap between Indigenous and non-Indigenous	Females – gap between Indigenous and non-Indigenous
Australian Aboriginal and Torres Strait Islander	56.0 years 67.2 years	63.0 years 72.9 years	20.6 years 11.5 years	19.0 years 9.7 years
New Zealand Maori	69.0 years	73.2 years	7.3 years	7.9 years

Canada First Nations	68.9 years	76.6 years	7.4 years	5.2 years
USA American Indians/Alaskan Natives	67.4 years	74.2 years	6.7 years	5.3 years

The inequalities in life expectancy between Indigenous and non-Indigenous Australians are obvious – ***but only if and when we look***.

Between 1901 and 2006 average life expectancy at birth for Australia's population increased by 21.4 years for males and 23.3 years for females.[6] Between 1960 and 2004 life expectancy for Indigenous Australians increased by 8 years for males and 14 years for females [7] and the gap between non-Indigenous and Indigenous life expectancies declined for women from over 20 years in the 1960s to around 15 years in 2004; but the gap between non-Indigenous and Indigenous males increased from 15.5 to 17.7 years.[8]

At the suggestion of another colleague that I should use the same base year for this comparison I searched the literature to find that there were no reliable data to use to calculate the life expectancy of Indigenous Australians in 1901 – nor, indeed, until the 1960s.

In 1897 a politician in a Queensland Parliamentary Debate had said:

> "I have always advocated that the greatest possible assistance should be given to the race from whom we have taken this territory, and to whom we owe a great debt of gratitude for the splendid possession we have. The least we can do is to make their time here, which will not be a very long time, as pleasant as possible, and their departure as gentle as circumstances will permit." [9]

Between 1901 and 1967 the Australian Commonwealth Constitution Act stated that

> 'in reckoning the numbers of the people of the Commonwealth […], aboriginal natives shall not be counted.' During the lead up to the 1911 census the Commonwealth Attorney-General stated that persons of half or less Aboriginal or Torres Strait Islander descent should be included in the population figures. So all Aboriginal people encountered who agreed to complete the census were required to state what proportion of their heritage was Aboriginal. If they stated that they were more than half Aboriginal they were excluded from published census results. Torres Strait Islander people were viewed as 'Aboriginal natives' until 1947, and were, after that included in

> the censuses because the Constitution did not explicitly deny their inclusion. It was not until a national referendum succeeded in 1967 that changes were made to the Australian Constitution to allow the Commonwealth government to make laws for Aboriginal people and to include Aboriginal people in the reporting on the Census. Not until 1984 was a national initiative implemented requiring all states/territories to fully identify Indigenous Australians in their births and deaths data collections.[10] [11]

This is an example of inequality that is socially constructed – of unfair, unjust social treatment that was embedded in the core legal framework of the nation. It illustrates one of the multiple consequences of the ways of seeing and thinking and of decisions made by the nation's leaders in the 18th and 19th centuries – so that in 2013 we still do not have complete, accurate social (including health and deaths) data on Aboriginal peoples and Torres Strait Islanders.

Since the 1980s there has been growing epidemiological evidence of inequalities in the distribution of health in populations, including in the distribution of risk behaviours and, more gradually, in the distribution of the social determinants of health[12] [13] (economic and social conditions that influence individual and group differences in health status).[14] In 2013 there is overwhelming evidence that socioeconomic status and health status are strongly, positively associated.

Within the Australian population, for example, the average life expectancy of 20 year-old men and women with less than 12 years' education is 4.6 years less than that of their peers with more than 12 years' education. And among the same age group, the difference in average life expectancy between those in the highest and lowest income quintiles is a little more than 6 years.[15] Males in the lowest socioeconomic quintile have a life expectancy that is four years shorter than that of males in the highest socioeconomic quintile; for females the gap is two years.[16] On almost all measures people living in socioeconomically disadvantaged areas experience poorer health and are exposed to greater risks to health.[17]

However, within the social groups living in socioeconomically disadvantaged areas there are further inequalities in life expectancy. The significant difference in average life expectancy between Indigenous and non-Indigenous Australians has persisted for more than two centuries. No matter what the cause of death, no matter what illness or injury, and no matter what indicator of social or economic disadvantage is used, Aboriginal peoples and Torres Strait Islanders are over-represented in the least socioeconomically advantaged social group. The inequalities have been persistent and systematic. This is not explicable by chance; nor is it explicable by the life choices made by Aboriginal peoples and Torres Strait Islanders, themselves.

Why is it proving to be so difficult to reduce these inequalities in health and life expectancy?

Given that this evidence is not new, why have Australia and other western democracies been unable to make greater, faster progress in reducing inequalities in health? Why have we, as societies, continued to allow inequalities in health to arise and persist, given a widespread commitment (in principle at least) to social justice and equality, and the long-standing, convincing evidence of the existence of inequalities in health and growing evidence of the costs of these to individuals, groups, and societies?

This exploration of reasons for slow progress necessitated a return to examine some of the assumptions upon which so much of the work on inequalities in health has been based, in part because existing explanations of inequalities in health, of their causes, and of plausible interventions to reduce them appear not to be sufficient. The analysis of the 'causes of the problem' appears to be insufficient to enable societies (through their institutions and actors) to take effective steps to eliminate (or at least reduce) inequalities in health.

The first assumption to be examined is that of the distinction between inequalities and inequities in health – a difference that can, at first glance, appear to be semantic.

Health inequality is a generic term designating differences, variations and disparities in the health of individuals and social groups.[18] Inequalities in health are an inevitable (and indeed, in some respects, necessary and desirable) part of human existence. Inequalities can be measured. Perhaps most significantly, inequalities are not inherently unfair or unjust. Not all inequalities are avoidable; not all result from unfair, unjust social treatment; and not all are considered to be remediable by society (including, but not only, the state).

Health inequities on the other hand are inequalities in health that are judged to have arisen from avoidable, unfair, and unjust social treatment;[19] from 'differences in population health status and mortality rates that are ***systematic, patterned, unfair, unjust, and actionable,*** as opposed to random or caused by those who become ill.' [20]

Implicit in Whitehead's definition is that the decision as to which inequalities are unacceptable is 'not a scientific matter, but is, rather, conditioned by ethical criteria and political priorities'.[21] Different people, groups, and institutions apply different ethical and moral criteria (values), and have different political priorities when making the decision as to when inequalities are inequitable (and hence, merit remediating action by society). As well decisions differ over time – in response to new information, or to experience, or to changes in attitude.

Three questions arise from this understanding that inequalities become inequities only after a decision has been made that they arise from unfair, unjust, avoidable social treatment. One question is 'what constitutes unfair, unjust social treatment'? The second question is, 'who decides?' The third question is 'which social institutions and actors are responsible for remediation?'

In modern western democracies over more than a century a commitment to social justice has been used to guarantee all citizens access to the social goods and services necessary to enable them to participate in political and social life and to exercise the rights and obligations of a full citizen.[22] The rights have been hard won, but in these countries, *foundational equality* (all humans are born equal and our lives are of equal value), *formal equality* (that all citizens have formal rights and entitlements), and *political equality* (that all citizens have the right to vote, that one person = one vote, that one vote = one value, and that almost all citizens have the right to stand for office)[23] have all been enshrined in legislation and policy. However, although there is widespread agreement that social justice includes the guarantee of equal life chances (*equality of opportunity)* for all people, in practice all societies differentiate between inequalities arising from unjust, unfair, social treatment and inequalities that arise from the unequal distribution of merit and talent, and from informed personal choices. And there is continued disagreement about whether *equality of rewards or outcomes* should be (or can be) used as a measure of social justice.

Why is this important?

Inequity requires social and moral judgements to be made to 'bring it to life'. The values and beliefs embedded in the policies and practices of social institutions of governance and the values, beliefs, and experiences of their actors play critical roles in determining when inequalities are inequitable and in deciding whether it is their responsibility to act. This differentiation highlights the distinction between inequalities in health and inequities in health – the former being foundational, observable, and measureable; the latter being socially constructed and measureable only by comparison with pre-determined standards (e.g. the poverty line, or a population average).

Not all inequalities are avoidable and some are desirable or necessary to human survival and development. Inequalities in the distribution of many social phenomena, however, are indicators of a society falling short in its commitment to social justice. However, the point at which inequalities become inequitable is the outcome of social decisions made by institutions and their actors – based on a combination of institutional and personal values and commitments. The priority given to different values varies widely. There is no 'right' answer then to the question of when inequalities are unacceptable to societies. Through political parties, parliaments, and the social institutions in the public and private sectors, and in civil society we make decisions about what constitutes social justice, about the priority given to equality (in comparison to other values), about when inequalities are an outcome of unjust, unfair social treatment, and about who is responsible to remediate the situation.

Some people view liberty, efficiency, or safety as values of higher priority than equality within their conceptualisation of social justice. Some regard inequalities in health (or access to other social phenomena) as an outcome of individuals' and groups' exercising free will and personal choice (irrespective of the social conditions within which the decisions are being made); others regard inequalities as a necessary and inevitable consequence of a market economy. Moreover, such values are reflected in the legislation, policies, and practices of organisations, including governments and the market. They are often unquestioned – taken as 'given' and as unassailable. But every policy, every law, and every guideline or standard used by every organisation and their actors is based on assumed values and each is socially constructed.

Each set of perspectives (values and ideologies) leads to a different response to the question of when, if at all, do the state (and the organisations responsible for governance in societies) have an obligation to act to reduce or eliminate inequalities in health (and/or in the distribution of other social goods)?

One of the reasons that modern democracies have been slow to reduce inequities in health is arguably, that there has been widespread acceptance (particularly, although not only, by people in positions of political power) that the foundational, formal, and political rights guaranteed equally to citizens are sufficient to also guarantee equality of opportunity. One reason for slow progress toward eliminating inequity is that there has been limited recognition that inequity arises from unfair, unjust social treatment – it has, instead, been assumed that the foundational, formal, and political equalities guaranteed to all citizens are sufficient protection against this.

It is arguable, perhaps, that the experiences of the 19th and 20th centuries saw this logic play out on a large scale. Out of conflict and over time, nations slowly enfranchised (most of) their citizens and established foundational, formal, and political equalities, which in turn enabled the formation of effective social/political movements which were responsible for progress toward a more equal distribution of social goods, rewards, and burdens, and, as a consequence, improved life expectancy and health for the majority of citizens in western democracies.

Over recent decades, however, the dominant ideology of western democratic governments has regarded individual, personal liberty as a primary social value, with the corollary that individuals are entirely responsible for their lives (and health), that almost all social intervention is a violation of individuals' liberty, and that it acts as a barrier to the efficient operation of the market.

Rawls though spoke for many who viewed the evidence of inequalities arising systematically as a consequence of individuals' social position as an indicators that governance has failed in one of its prime responsibilities – i.e. to ensure fair access to basic goods and opportunities that condition people's freedom to choose among life-plans they have reason to value. The logical corollary of this is that social action is, then, required to redress unfair social treatment.

In short, two of the reasons for slow progress in reducing inequities in health are that the decisions about when inequalities are inequitable (the result of unfair, unjust social treatment) depend upon the values, beliefs, and political power of those who make the decision; and the decisions about whether it is the role of the state (and the institutions of governance) to act depend upon whether decision-makers view inequalities as resulting from unjust social treatment or from the freely-chosen decisions of individuals. One of the reasons that progress in reducing inequity has been that social institutions and their actors have not been concerned about it – regarding it as a necessary (and for some, even, desirable) component of social and economic development.

This understanding of the nature of inequity leads to a critical shift in focus - from a single, primary focus on 'what to do' (to eliminate inequities) to include an additional focus on who decides when social treatment is unfair and unjust, and who decides on what action, if any, is to be taken to reverse this.

What does this mean for health promotion practitioners (and policy makers)?

The health of populations and individuals is determined by multiple factors – some genetic or biological, and some individual and social group choices. However, people also require education, meaningful work, income, secure food and water supplies, housing, transport, health care, and safe environments in order to become and stay healthy. The right and freedom to participate in economic, social, political and cultural relationships also determine the health of individuals and populations.

Whitehead identified seven determinants of inequalities in health:

1. natural biological variation
2. health damaging behaviour if freely chosen, such as participation in certain sports and pastimes
3. the transient health advantage of one social group over another when that group is first to adopt a health promoting behaviour (as long as other groups have the means to catch up fairly soon);
4. health damaging behaviour where the degree of choice of lifestyle is severely restricted; ✖
5. exposure to unhealthy, stressful, living and working conditions;□✖

6. inadequate access to essential health and other public services;□✖
7. natural selection or health-related social mobility involving the tendency for sick people to move down the social scale.

From among the seven determinants of inequalities in health Whitehead judged three (marked with an X) as determinants of inequity – as an outcome of unfair, unjust social treatment. In a clear example of the role of judgement in deciding on whether inequalities are an outcome of unjust, unfair social treatment Whitehead did not, in this list, judge the tendency for sick people to move down the social scale to be a determinant of inequity although others would clearly judge it to be unjust, unfair social treatment.

What is also striking in the framing of each of these determinants of inequalities and inequities in health is that they describe the consequences of unequal social treatment for the groups of people who have been affected – rather than describing the maldistribution of economic resources that actually constitutes the unfair, unjust, and avoidable social treatment.

The other factor missing from this analysis is any reference to the demographic and social/cultural characteristics of the people who are affected and to any observable patterns within the population groups affected.

This overlooking of the composition of the social/cultural groups experiencing inequity is a critical issue. Because not all members of all social groups have equal chances of being affected equally by unjust, unfair social treatment – rather, some social groups are at much greater risk of such social treatment than others (no matter what ‘social good or service or reward or burden’ is being distributed; no matter which indicator of health is used). Unfair, unjust, avoidable social treatment does not fall randomly across populations.[24]

Thus, two further reasons for slow progress are that most of the measures of health inequalities and most of the analysis on the determinants of these focus on socioeconomic status. The distribution of social groups within economic classes has received much less recognition and the added burden of disease and premature death experienced by some groups within economic classes has not been identified. In societies in which foundational, formal, and political equality have been guaranteed, it has either been assumed that every citizen has an equal opportunity to access the goods and services necessary to overcome socioeconomic disadvantage, or to avoid ill health and premature death, or it has been assumed that the maldistribution of economic resources is the primary determinant of inequalities in health. These beliefs have persisted despite the evidence to the contrary.

What is clear is that inequity is an outcome of decisions we, as individual citizens, as social actors, and through our institutions of governance, make about the distribution of the social determinants of health. The Commission on the Social Determinants of Health recommended four groups of actions to eliminate the inequities in health that had been identified:

- ensure equal access to conditions of everyday living conducive to health;
- redistribute money, power, and resources;
- increase and disseminate knowledge, monitoring and skills; and
- build coherent global action.

The Commission's analysis reflected the evidence that the primary sources of inequities in health are rooted in the socioeconomic structures of societies – in the structures and processes responsible for the distribution of the material resources to which all people and populations need access if they are to survive and thrive.

The actions recommended by the Commission focused on what Nancy Fraser called the politics of redistribution – understanding that the unfair, unjust social treatment that is rooted in the economic structures of societies, and that to reverse this requires governments, the market, and civil society to act to reduce material deprivation. The politics of redistribution views differences in access to social goods, services and resources as a socially constructed outcome of an unjust political economy. The remedy, by this analysis, is to abolish differences in social treatment across groups that are defined primarily by socioeconomic status. There are multiple examples of interventions built around the analysis of injustices arising in the socioeconomic sphere.

The institution of the welfare state was one population-wide measure intended to redress injustices rooted in economic structures. This primacy given to the need for redistribution of economic resources was reflected again in a very recent study of the Indigenous- non-Indigenous life expectancy gap in the Northern Territory that concluded that reducing poverty should be placed squarely at the centre of the strategies to close the gap.'[25] As well, in a multitude of projects and initiatives the public health workforce has worked with politicians and policy makers in the health and other sectors, with practitioners and communities, and with researchers and activists in efforts to increase the access of disadvantaged groups to the social determinants of health. We have advocated for universal and targeted health care, and for social support, social inclusion, and material assistance for disadvantaged groups. We've worked directly with residents of social housing, with people who are unemployed and their social service providers, and with Aboriginal populations affected by the Northern Territory Emergency Response.[26]

Another approach based on evidence of the relationship between economic injustice and health inequity has begun to evolve, with the health sector finding ways to join with other social policy sectors to form 'both springboards' and safety nets' that are sufficient to enable people who have been pressed to the margins of communities and society to move out of marginal existence and to take up opportunities to participate in education and employment.[27] Providing people who were homeless with a secure home as well as ready access to health care, social support, and sufficient income to survive with dignity is one example of this approach to equalising the distribution of social resources.

The Commission recommended the redistribution of money, power, and resources between social groups at global, national, and local levels – as the means by which to create and ensure access to the positive conditions for everyday life for everyone. The Commission recognised that it would be necessary to redistribute power in order to enable marginalised groups to argue directly on their own behalf for the economic resources they require to survive and thrive. These were ground breaking recommendations – intended to eliminate inequalities in opportunities to access and use social and economic resources.

The politics of redistribution views differences in access to social goods, services and resources **not** as an outcome of the intrinsic properties or qualities of social groups but rather as a socially constructed outcome of an unjust political economy. The remedy, by this analysis, is to abolish differences in social treatment across social groups.

The Commission on the Social Determinants of Health took this approach too. It recommended that reducing health inequities would require changing the distribution of power within societies and global regions, empowering individuals and groups to represent strongly and effectively their needs and interests and, in so doing, to challenge and change the unfair and steeply graded distribution of social resources (the conditions for health) to which all, as citizens, have claims and rights.[28]

These were significant conclusions – drawing attention to the role of power as a determinant of health. The unjust distribution of economic resources is the problem (maldistribution) and increasing marginalised groups' access to (and use of) political power is an essential prerequisite to their achieving the redistribution of economic resources. This analysis views power as having instrumental value – as an essential means by which previously marginalised groups are able to bring about the redistribution of social goods and resources so that the opportunities to access/acquire them are equally distributed and so that the negative consequences of inequitable access (including health consequences) are reduced or, preferably, eliminated.

Although it has taken decades there is now growing understanding on the part of governments and their institutions (some), on the part of civil society organisations (some), and on the part of their actors (some), that equal opportunities to access economic goods and resources are necessary prerequisites for health and health equity. However, there has been much more limited understanding of why the distribution of the goods and resources has continued to be unequal – why are some social groups denied, systematically and persistently, the access to social goods, services and rewards that we have known for decades that they need?

This means returning to my earlier points that government, its institutions, the market, and civil society and we, as actors, make decisions about the distribution of the social determinants of health. We decide on priority populations, on the recipients of programs and services, on the locations in which the programs and services are offered, on the size and scale of investment, and on who acts. The question of who is deciding is masked by the fact that the positions held by the actors are defined by the demands of the position or role, that the knowledge and skills of the actors (and the decisions made) 'fit' the role, and that, as responsible, publicly accountable, trained actors, we make rational decisions based on an unexamined belief in evidence-based policy and practice.[29] It is assumed 'not to matter' who decides – that the social, cultural and economic characteristics of decision-makers and the values and beliefs they/we hold have limited (or no) influence on public policy decision-making.

The evidence, though, demonstrates this not to be true – the patterns of 'winners and losers' from public policy decisions are predictable and long-standing. A recent equity focused health impact assessment conducted on a plan for the introduction of a new delivery system for renal services for people with end-stage kidney disease in a metropolitan LHD found that the greatest need for services such as dialysis and support for self-management was from the population living in an LGA in which no such renal services were being provided.

A review of the literature on smoking cessation interventions among groups with high prevalence of tobacco smoking found that actors within the health sector had decided against such interventions for each of the groups – without consultation. Although on occasion the reasons for such decisions might have been defensible, the lack of informed choice given to clients and community members was a glaring failure in the duty of care.

Each of these decisions about the need for and provision of services was made by policy actors and professionals – including population health professionals. The social groups who were most negatively affected by these decisions were the same in each case. This is reflected in the evidence that some social groups who share low socioeconomic status but who do not share all other social/demographic/cultural characteristics are over-represented in the low socioeconomic group, experience higher burdens of disease than the others in that group, ***and*** are more likely than others in the low socioeconomic status group to die prematurely.[30] In other words, the injustice (inequity) arising from economic sources is not the only form of injustice experienced by some groups.

Williams identified historically marginalised, ascriptive groups for which:

- patterns of social and political inequality are structured along the lines of group membership – the patterns have been stable over time and systematic;
- membership of the groups is not usually voluntary or mutable; and

- negative meanings have been assigned to group identity by the broader society or dominant culture.[31]

Such groups are not economically defined classes. Fraser described the injustices experienced by these groups as arising from social subordination. The subordination is recognisable as cultural domination (being subjected to patterns of representation, interpretation, and communication that are associated with another culture and are alien and/or hostile to one's own); non-recognition (being rendered invisible in the representational, communicative, and interpretive practices of one's own culture), and disrespect (being routinely maligned or disparaged in stereotypic public cultural representations and/or in everyday life interactions).[32]

All social institutions (including political, legislative, market, and civil society) have inherited policies and practices developed in previous eras. These continue to shape contemporary discourses on problems and solutions. In the case of Aboriginal peoples and Torres Strait Islanders in particular, this means that state (and dominant-society) supported discrimination has been 'carried forward by the force of political inertia'[33] – and 'the bulk of spending on public policy is devoted to programs that the government of the day inherits from its predecessors and transmits intact in the legacy that it leaves to its successors.' [34] These patterns of injustice and negative meanings assigned to group identity are embedded as well in the ways in which the actors working from institutions, and most citizens see and think. The patterns and meanings are, largely, invisible to the institutions and their actors, and to the majority of citizens – so deeply held and embedded that the need for change goes unrecognised.

Fraser went on to name this form of institutionalised subordination of some social groups as misrecognition. To overcome this would, in her view, require the replacement of value patterns (held within institutions and their actors) with new patterns that guarantee and deliver political equality in all social arenas – so that the autonomy, trust, social respect, and self respect that flow from participatory equality are available to enable self-determination.[35] Recognition (as in being present in structures exercising political power, and being influential in the processes of public decision making) is an independent determinant of health – beyond the instrumental value of power.

Expanding access to political equality: rethinking power

Lukes famously identified three dimensions of power in societies:

- being at the decision-making table at which agendas are set, issues discussed, and decisions are made;
- having the ability to influence which items 'make it' for consideration on the public agenda, the ways the items are discussed, and the final decisions made; and

- having the capacity to recognise and formulate one's own and one's group interests free from the domination of others.[36]

Political power is available to and distributed by the state, the market, and civil society. One of the manifestations of political power is the ability of those who have it to insert a system (albeit not necessarily coherent) of values or ideals and/or goals into decision-making processes and policy outputs. Political power is not only comprised of the formal, externally verifiable structures, rules and processes governing societies and communities, but is also comprised of the personal values and goals of the people who are responsible for its application, and of their self-regard. Political power is vital to health equity not only for its instrumental value; it is independently vital for its symbolic value.

Political power is exercised in multiple spaces – legislative, policy, civil society, and the market – through the enactment of or guidance from legislation, policies, and through the accepted practices of the *actors* in all social practices and arenas including employment and markets; family and personal life; formal and informal politics; public goods and services; and associations in civil society. [37]

Not only have historically marginalised, ascriptive social groups been subjected to economic subordination, they have also been largely invisible within the spaces and among the actors responsible for social decisions – status subordination. Although power can be exercised by external actors – lobbyists and advocates; members of social movements; and well-connected individuals, both lack of resources and lack of recognition limit the capacity of some social groups to use these pathways, particularly when the groups are small minorities within a dominant population. Such groups rarely have access to Lukes' first dimension of power – 'being there'.

Beyond 'being there' however, Lukes' identified a second dimension of power - the ability to influence which items make it for consideration on the public agenda, the ways in which the items are discussed, and the final decisions that are made. Such power is embedded in the laws, and policies, and practices of society and its institutions, and their actors. Some examples include: the cultural biases of items used in the educational testing of children; the continued investment in health promotion to reduce behavioural risk factors over investment in fair, just social treatment; the locations selected for social housing, the styles of housing, and the accessibility of public infrastructure and services. Misrecognition means that items that make it for consideration on the public agenda do not reflect the priorities or perspectives of marginalised social groups, or that if an item does make it to the public agenda the absence of representation of marginalised, ascribed groups and/or the negative meanings ascribed to their contributions means that debate about problems and solutions is framed without reference to the groups' perspectives and preferences[38], and that decisions, too, are made without their influence.[39]

In Australia the groups most clearly denied equal opportunities to access and acquire political power are Aboriginal peoples and Torres Strait Islanders, although it is also true that other social groups on the grounds of disability, or religion, or culture, or gender, have been ascribed lesser status by the dominant society. But using life expectancy as the indicator, it is arguable that the greatest impact of misrecognition has been (and continues to be) on Aboriginal peoples and Torres Strait Islanders.

Finally, Lukes identified a third dimension of power – the capacity to recognise and formulate one's group's interest free from the domination of others. Jones[40] saw that this would require that historically marginalised ascribed groups have legitimate spaces in which to build and exercise this capacity. She saw, too, that the groups would need to overcome the internalised oppression that limits their own recognition of the right to political power and of the pathways to access such power. This is not easy – the consequences of inequitable social treatment run deep within people and communities. Part of the architecture of oppression is to dismantle and denigrate all the structures and processes that social groups need to survive and thrive. [41]

The negative meanings to Aboriginality ascribed by the dominant society were and are experienced as everyday racism by Aboriginal peoples and Torres Strait Islanders. Social institutions are unsafe places in ways that are invisible to the dominant society but that are all-too-obvious to Aboriginal peoples and Torres Strait Islanders.

In the same way that we and our institutions measure and speak of the unequal distribution of socioeconomic resources without acknowledging that it is the same institutions that are responsible for that distribution, the naming of population groups as 'at risk or vulnerable' populations fails to recognise that the risk and vulnerability arise from the discriminatory, oppressive policies and practices of society's institutions and its actors. This is a significant difference in perspective, because problems arising from these causes cannot be remediated by the people who have been the objects of the oppression and discrimination – the source lies within the institutions and actors responsible for the meanings ascribed to these social groups. Nor can the unjust social treatment arising from these sources be remediated by redistribution of socioeconomic resources (economic justice) alone. Even if the distribution of socioeconomic resources becomes more equal the causes and harmful consequences of misrecognition remain intact.

These determinants of health inequity can be addressed only by the combination of recognition[42] and presence[43] or representation.[44] [45] Being powerful – as well as having the capacity to 'speak truth to power' – is an indicator of full citizenship, of self-determination and autonomy, and is a vital step toward overturning ascribed, negative social status and eliminating its terrible health consequences. Participating fully in social decision-making has an independent, direct positive impact on health.

In democracies in which formal and legal equality are guaranteed to all citizens there are some who argue that it is only after economic justice has been achieved that attention should be turned to providing equal recognition for all citizens. However, this, too, assumes that distributive justice is more important to health equity than what might be termed political justice or equality. There is at least some evidence that the reverse is true – that recognition and presence are prerequisites for (or at least contribute positively to) distributive justice.[46]

What does this mean for action to eliminate inequities in health?

There are significant implications for practice arising from the understanding that the politics of recognition is as important to reducing inequities in health as the politics of redistribution. To make progress, need to expand the political power of groups who have been marginalised it is necessary to address the sources of misrecognition by enabling equal opportunities for representation in and influence on decisions about the distribution of the determinants of health – by demonstrating public recognition of and presence in the structures and processes through which we govern ourselves.

Simon Szreter saw this in the earliest successes of public health. He recognised that the population-wide health benefits of improved housing, improved sanitation, and improved working conditions were achieved only after significant proportions of the population had been enfranchised over the course of the 19th and 20th centuries and had fought for the implementation of legal, engineering, and social changes.[47] Kymlicka[48] recognised that the improved political, economic and social conditions that characterised that period were achieved by majorities of citizens who sought equality by challenging the powerful minorities that had governed previously. By the end of the 20th century, however, in western democracies the greatest economic and social injustices were being experienced by minorities – by small social groups that had been ascribed a negative social status and that could only rarely command a majority in social decision-making. Representative democracy evolved based on the preferences of the majority – leaving little space for minorities to participate independently or to influence public agendas and outcomes when their needs and aspirations are separate from those of the majority.

> ‘The problem is not simply that some people do not get the government they want, but rather, that minorities do not get what they want on issues which are of importance to them but to which the majority is relatively indifferent.’[49]

What does this mean for health promotion practice in the 21st century?

Democracy was founded on the principles of inclusion and engagement – on an understanding that social decisions are best made by the people who affected by those decisions. Health promotion was based on this same understanding – on the principle of empowerment so that people have the capacity, resources, and opportunity to improve and maintain good health through social action, community organisation, and collaboration with health care service providers and with other sectors, including the market and civil society.

However, despite their obvious successes neither representative democracy (as it has evolved in western democratic nations), nor health promotion has been able to eliminate inequities in the distribution of health and mortality. Although multiple versions of community organising and empowerment have been devised and implemented, none has been sufficient to overcome the political inequality of groups that have been subjected to status subordination and have had limited opportunities to acquire and exercise political power – at local, national or global levels.

Paul Keating in his famous Redfern speech[50] on the occasion of the Year for the World's Indigenous People said 'I think it begins with that act of recognition', and went on to say that 'perhaps when we recognise what we have in common we will see the things which must be done – the practical things.'

For Aboriginal and Torres Strait Islander people 'Health is holistic, the outcome of multiple inter-related factors which can be spiritual, environmental, ideological, political, social, economic, mental, and physical. When the harmony of these is disrupted, Aboriginal ill health will persist.'[51]

In this Oration so far I have postulated that misrecognition and lack of presence/representation are direct determinants of health. It is important to understand that the misrecognition is the responsibility of the policy actors and practitioners that contribute to the social treatment that create and perpetuate or tolerate inequity. Aldrich showed that 'it is highly probable that the discourses of the public policy environment shape policy emerging from that environment, and that those who participate in the discourse influence policy content.' [52]

The purpose of the proposed actions, below, is to afford social groups experiencing status subordination not only the right but also the opportunity and actuality of equal participation in the structures and processes through which we, as a society, govern ourselves; and to enable their direct representation and participation in decisions about the distribution of social determinants of health.

The steps below are suggested as ways in which institutions responsible for social treatment (in our case, health promotion) can strengthen and expand the actions taken to eliminate the systematic, patterned, unjust, unfair social treatment that has resulted in health inequity. Fraser argued that the integration of redistribution, recognition, and representation provides our best hope for overcoming injustice in the present political, economic, and social context.[53] Implicit in her work is the need for the presence and representation,[54] [55] for the establishment of structures and processes that enable new conversations and interpretations that understand and respect differences and that reach consensus on ways forward that result in real political equality and substantive outcomes[56] among the social groups who need not only economic justice, but also political justice – an equal political voice for every citizen.

> ‘If you have come to help me you are wasting your time. But if you have come because your liberation is bound up with mine then let us work together.’[57]

POWER WITHIN	PRESENCE & REPRESENTATION	CREATE RECOGNITION SPACES AND NEW MEANINGS	DECIDE BY CONSENSUS	EVALUATE CHANGES IN POLITICAL POWER AND EQUALITY
Recognise and support the strengthening of cultural and political communities	Mandate presence and formal, descriptive representation	Contribute to creating shared meaning – ensuring that all groups are full partners in social interactions – and that new knowledges and	Deliberate to reach decisions by consensus	Measure substantive outcomes

Lukes’ third dimension of power: support communities to build cultural and political strength – to create own agendas free of manipulation

Strengthen cultural communities among ‘groups of people who share a culture and draw their identities from common languages, histories and traditions’.[58] Communities need space, time, resources and trustworthy guarantees that the items they identify for inclusion on the public policy agenda are, in fact, included on that agenda. Communities also need space, time, and resources to identify leaders and constituencies in readiness for joining and contributing to political communities. There is a strong body of evidence developed by Indigenous organisations and communities to advise on and guide actions to improve governance.[59] [60]

Strengthen political communities - ‘groups of people who live under the same political rules and structure of governance and share status as citizens’[61]. ‘The most highly contested and passionate political fights are about membership’ [62] no matter where and at which level of governance. Integrating multiple cultural communities into a single political community without destroying or sacrificing their identity or integrity is a significant challenge when the history of discrimination and exclusion is so deep and when it has been confirmed by contemporary experience (as in the Northern Territory Emergency Response for example). Nonetheless, political communities are essential both to the selection and election of leaders to positions of power – and to the achievement of positive outcomes.

Lukes' second dimension of power: mandate and expand descriptive representation within all decision-making structures and processes

There is long-standing evidence of the patterned, systematic unjust, unfair social treatment that has been delivered by society's institutions to social groups that are rarely present in social decision-making. Much greater emphasis is needed to achieve at least proportional (descriptive) representation in decision-making. Beyond that is the need for greater understanding of and transparency in describing what is meant by 'representation' (see below).

The politics of presence focuses attention on who decides when inequalities in health (for example), are inequitable – when social treatment is unjust and unfair? Who decides whether and when, it is the role of society to respond? Who is 'at the table' when the public agenda is set, when the causes of problems are framed and when decisions are made about appropriate responses?

The evidence is clear enough. 'Senators (in the US) have proven highly responsive to the opinions of wealthier constituents and wholly unresponsive to the preferences of the poorest third of their constituents'[63] and 'when Americans with different income levels differ in their policy preferences, actual policy outcomes strongly reflect the preferences of the most affluent but bear virtually no relationship to the preferences of poor or middle income Americans.'[64] The need for full, active participation in political communities is supported by evidence that the values of the Senators (as reflected by their political party affiliations) were significant in determining their voting patterns.

There is growing empirical evidence of the significance of presence as an independent influence on the outcomes of social decision-making. [65] [66] [67] [68] 'Being there' is critical – particularly for groups seeking to redress historical injustices that have become embedded in institutional practice. Even in 2013 it is all too common to find that public policy decisions are being made in the absence of Aboriginal peoples and Torres Strait Islanders (in particular). In terms of health promotion this is of particular concern – because it is ignoring the fact that 'political presence' is an independent determinant of health, and because it is denying the fact that Indigenous knowledge, systems, and practices are essential to develop effective health promotion interventions.

Presence is essential. However, presence is intimately linked with the issue of representation – itself a complex concept that requires deep investigation, particularly by and with social groups that have had no opportunity to explore or test ways to ensure that they are adequately/appropriately represented in public decision-making arenas. Who represents whom in decision-making is a significant, separate concern when focusing on eliminating injustice. I have not addressed it in detail here – suffice to say that 'the inclusion of a single person from a marginalised community who has limited formal approval from that community as their spokesperson or 'representative' is clearly not 'presence' leading to more just, fairer social treatment and outcomes. For more detailed and expansive exploration of this issue see Celis et al.[69] and Mansbridge.[70]

That points to two relevant issues. The first is that being 'in power' - being a politician or being a leader within organisations responsible for governance in all social arenas matters. Descriptive representation is a significant contribution to the direct impact of political power on the health of historically marginalised ascriptive populations (symbolising respect and public recognition, as well as enhancing self respect and autonomy). However, the second issue is that it is also necessary to be able to use the power to achieve equitable distribution of social resources. Social groups need not only to be seen to be represented or present - they also need to be able to influence decisions on agenda items, on solutions to problems, and on implementation.

Given that the health sector (and units or services within it) are political communities, their membership is significant. A first step in re-thinking power is to seek to ensure descriptive representation of marginalised, ascribed social groups. Is there proportional representation on decision-making bodies? Who are the 'representatives' and how are they selected? Who is the constituency being represented, how transparent is the process by which representatives are selected, and what mechanisms are in place for information exchange and feedback?

Lukes second dimension of power: overcoming history - creating shared meaning/recognition spaces [71]

One of the forms that unjust, unfair social treatment has taken has been the exclusion of historically marginalised ascriptive social groups from most forms of social decision-making – even after formal and legal equality had been established. The harms to the groups resulting from that exclusion are well documented. However, the sources of the injustices have gone largely unrecognised and unaddressed. The institutions and actors responsible for the implementation of institutional policies and practices remain blind to or ignorant of the need for the adoption of new value patterns that promote equal participation in social life.[72] It is salutary to remember that most of the policies inherited by Australian institutions reflect the negative meanings ascribed to minority social groups (Aboriginal peoples and Torres Strait Islanders, people with disabilities for example); nor are these groups are not represented descriptively (proportionally) in most social decision-making structures and processes, including the workforce.

In short, they continue to ignore the fact that 'the claims of culturally different peoples to self-determination and autonomy require that political coherence is established by constant inter-cultural dialogue (where different groups reciprocally and freely contribute their cultural understandings and can act autonomously based on their mutual recognition).'[73] [74]

It follows that, if it is to be possible to eliminate inequity, two of the most important steps needed are to create recognition spaces[75] and processes that enable 'constant inter-cultural dialogue' using deliberative methods that mean that participants engage with mutual respect, as free and equal citizens in a search for fair terms of cooperation – and without the threat of the coercive power.[76]

Lukes' second dimension of power: exposing institutional inheritances

It is also necessary to expose the institutional inheritances that frame contemporary decisions. More is needed from the actors who are responsible for decisions in the present institutions responsible for health promotion, for example, in our society currently – actions to expose the institutional policy inheritances that influence contemporary policy making, and to expose the influence of these on the knowledge, attitudes and practices of the actors responsible for developing and implementing policy. This includes reform within the health sector, beginning with examination of the inheritances with which we are working. For health promotion professionals it is necessary to examine our own and our institutions' policies and practices and to reflect on (and change) the ways in which they perpetuate inequity through misrecognition. This requires consideration of: what values, norms, and rules have been codified in policy and institutional practices that perpetuate or create inequity?

- who are the actors engaged in policy processes – how representative are they of the affected communities and how well connected are the actors with their 'constituencies'?
- what are the values, assumptions, knowledge, and experiences of the contemporary actors in those institutions?
- what opportunities are there to take more time to create shared meaning – to listen deeply, reflect, recognise differences and to arrive at new, shared ways of seeing and acting by consensus?
- what structures, resources, and spaces are available at the cultural interface to enable the conversations, deliberations, and negotiations to take place, and to enable decisions to be reached by consensus?

Lukes' second dimension of power: creating and expanding opportunities for 'creating shared meaning' in formal and informal ways

In addition to ensuring presence in decision-making however, further action is needed to establish spaces and processes at the cultural interface between Indigenous and Western knowledge systems for example, within which it is possible to achieve a balance of knowledge, skills, and confidence in working together to promote health (or to achieve other social goals). [77] It means reviewing the processes used for meetings, negotiations, and decision-making to incorporate cultural and experiential differences [78] [79] It also means creating and expanding opportunities to work together – hire people, listen closely and deeply; recognise that the same words and experiences can have different meanings; and change values, attitudes, policies and practices in response. It is only in these ways that the institutionalised social subordination that has been inflicted on Aboriginal peoples and Torres Strait Islanders (and other marginalised social groups) can be overcome.

Connected with actions to create spaces for and processes to develop confidence in shared meaning (about societies and their social decision-making structures and processes) is the need to use deliberative methods to conduct debate and to reach consensus decisions. This is of particular importance given that the social groups that have experienced the greatest level of exclusion from social decision-making are, now, small minorities. Decision-making based on majority preferences is a structural barrier to the achievement of equitable outcomes when the least recognised voice is that of a small minority.

> 'The more we face a question of basic rights or justice, the more important deliberation becomes and the less that question should be settled on the basis of power – even equal power.'[80]

Lukes' first dimension of power: achieving substantive outcomes

Finally, the goal is to achieve substantive representation and outcomes. The indicators of success are simple:

- representatives have placed community-driven issues on the agenda, that representatives are actively engaged in deliberation and decision-making
- the decisions have led to the intended results even at the expense of (or in comparison to) the majority.

However, achieving success will require significant changes in the ways we have been approaching the challenge of reducing (let alone eliminating) health inequity.

Making greater, faster progress toward eliminating health inequity

I began this Oration with the question as to why we (as a society) have much such slow, limited progress in reducing inequities in health?

I showed that inequity is only brought to life by human judgements – about social justice and its core components, about what constitutes unfair, unjust social treatment, about when social treatment is unfair and unjust, and about when a social response is activated. The implications of this are two-fold. First, that institutions and actors with political power make these decisions – and representative democracy has been able to ensure that the majority of people in a population are treated fairly and justly. Second, that social groups that have been excluded from establishing the policies and practices of the institutions of power and from being actors within those institutions have had no voice in deciding which social treatment is unfair and unjust, when it is unfair and unjust, and what actions are needed for them to achieve fair, just social treatment. Although there have been growing calls for the redistribution of political power to enable marginalised social groups to advocate directly for access to the goods needed to survive and thrive, there has been much more limited attention given to ‘why the redistribution of political power, itself, has been so difficult to achieve’?

Here, though, lay a further challenge - that of exposing the fact that the maldistribution of all social goods, including political power, has been patterned and systematic. Williams had identified some social groups – historically marginalised ascriptive groups – whose inherent biological, social, or cultural characteristics have been ascribed negative meanings by dominant societies and their institutions over centuries. Such groups, even when it is possible to achieve justice in the economic sphere (employment, income, transport, housing, etc), are still treated unjustly and unfairly.

Fraser named this misrecognition – as the social subordination of some groups through the mechanisms of representation, interpretation, and communication. The politics of presence drew attention to one of the ways to overcome misrecognition – albeit needing expansion to clarify the meaning and methods used to determine representation – and Lukes’ dimensions of power pointed to the layers of power needed by the social groups Williams had identified.

The analysis showed that, in addition to needing political power for its instrumental value in achieving the redistribution of social goods, services, rewards and burdens, historically marginalised ascriptive social groups require political power for its direct, symbolic value – as a marker of full participation in society in all social arenas, conveying both social and self respect, and equal recognition of the right to self-determination.

The actions required to achieve this however, require all the institutions and actors in all arenas of social interaction and decision-making – including the formal and informal political arenas, the market, and civil society – to expose and revise our ways of thinking and seeing the problems and solutions for which we are responsible, to take active steps not only to ensure the presence of marginalised groups in decision-making, but to reflect on and explore and evolve new meanings and understandings about problems and solutions and to act on them. Working at the cultural interface requires commitment to deep learning, to creating spaces within which this is possible, and to reaching consensus on ways forward.

Without such effort and action the injustices arising from social subordination, from the negative meanings ascribed to the inherent social, cultural, or biological characteristics of some social groups cannot be overcome. Health inequity will continue if the judgements about what constitutes unfair, unjust social treatment and who is being treated unfairly and unjustly are made only within the conceptual and policy frameworks that have been used to date, and if the judgements are made only by people who have assigned rusty halos to ‘the other’.

It is important as well to recognise that there are some theorists who believe that it is only when socioeconomic injustices have been overcome that it is possible to take action to eliminate misrecognition. It is my view that the opposite is an equally valid postulation – that it is only when groups that have not been recognised have political equality (or at least power) that it will be possible to achieve equitable redistribution of material resources.

Distribution and recognition are not neatly separated from each other – only by acting to address them together will it be possible to achieve what Fraser calls participatory parity and distributive justice.[81]

Health promotion is rooted in the principles of social justice and equity, and from its earliest manifestations the engagement of communities and individuals in taking control of their own health and in influencing the social determinants of health has been central to theory and practice. Alongside the professional practice of health promotion, societies everywhere have taken steps to improve the health and wellbeing of their populations – through implementing welfare systems (broad or narrow), through improved health care, and through other public policy initiatives (universal education for boys and girls for example).

However, despite the many successes it has proven to be impossible to eliminate inequity in health and there is some indication that inequity may be growing, even in wealthy nations. This makes it vital to consider what else is necessary because inequity is not inevitable. It is up to us, working within our institutions, professional and personal communities, to overcome the unjust, unfair social treatment arising from misrecognition and from denial of presence or direct representation. The challenge for those of us working in health promotion is not only to work with and support communities that had experienced subordination in new ways and to support and strengthen initiatives to acquire economic resources. It is also (and more fundamentally) up to us to:

- reflect on our own roles in creating and/or perpetuating inequity and to recognise the need for change;
- look within ourselves and our institutions, examine our actions, and to take positive action to change these to eliminate the unjust, unfair social treatment that is embedded in our policies, practices, attitudes and values;
- create (and where necessary, vacate) spaces and processes so that the people who have been denied economic and political justice can take their rightful places in determining the future – not only their own future but everyone’s future.

It will be a struggle – that’s the nature of politics – but as Gandhi said: ‘first they laugh, then they argue, then they fight, and then we win.’

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