

## 1. Introduction

Australian and international studies consistently show that social and economic factors affect health. People from lower socio-economic backgrounds have poorer health status compared with those with higher socio-economic status. Disadvantaged groups have higher death rates, more disability, more serious chronic illness, and are more likely to describe their health as fair or poor.<sup>1-5</sup> Differences in health are not just apparent between the most and least advantaged but show a gradient across all social groups.<sup>1,4</sup>

There are also differences in health behaviours and in the use of health services between socio-economic groups. People from low socio-economic groups are more likely to smoke, be physically inactive and overweight. Disadvantaged groups are more likely to use primary health services such as out patient clinics and GPs because of poorer health, but less likely to use preventive health services such as mammography screening and pap tests.<sup>6,7</sup>

A range of reasons to explain these differences has been suggested. These include the impact of social, environmental and economic conditions, such as poverty, income, education, living and working conditions; as well as more underlying psychosocial factors such as social support, control, social coherence, trust; and access to health services. The complex affects of these factors are thought to account for most of the observed difference.<sup>1-6,8</sup>

### 1.1 Rationale

#### Why Reduce Health Inequities?

Growing evidence of differences in health among social groups has attracted closer attention of researches and policy makers in recent decades. Discussions in the literature reflect major reasons why health inequities should be addressed.<sup>9</sup> First of all, the notion of **fairness** that everyone in the society should have ‘equal opportunities for health’. According to the definition by Whitehead:

*“Equity in health is not about eliminating all health differences so that everyone has the same level of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating equal opportunities for health and with bringing health differentials down to the lowest levels possible.”<sup>10</sup>*

Inequities become “unfair” when poor health is itself the consequence of an unjust distribution of the underlying social determinants of health (for example, unequal opportunities in education or employment).

Health in many instances is more than a matter of personal choice: the decisions that people make about health are shaped by the environment in which they are conceived, raised and live their adult lives. The growing evidence from research shows that children from disadvantaged backgrounds are more likely to have poor outcomes including health and social positioning in adult life.<sup>4,11</sup> The early correlates and consequences of child poverty for children and young adults include adverse trends in reading skills, unmanageable and aggressive behaviour at school, drug misuse, unemployment, teenage pregnancy, homelessness, crime, and suicide.<sup>12</sup>

Secondly, interventions to reduce inequities by improving the health of the most disadvantaged will **benefit all members of society**. Some types of health inequities have obvious “spill over” effects on the rest of society for example the spread of infectious diseases, the consequences of alcohol and drug misuse, or the occurrence of violence and crime. It has been proposed that wide differentials in income promote exclusion, lower thresholds for risk and violence, and weaken the social connections that make for healthy communities and focusing on the underlying economic and social conditions is thought to limit this.<sup>5,8</sup>

The social environment also influences behaviour by shaping norms, enforcing patterns of social control (for example alcohol free zones, no smoking areas), providing or not providing environmental opportunities to engage in certain behaviours, and reducing or producing stress for which certain behaviours may be an effective coping strategy.<sup>13</sup>

Thirdly, inequities are **avoidable**. Inequities are not a natural outcome of a wealthy and economically expanding society. Those countries that successfully support disadvantaged groups (such as Denmark and Norway) have achieved better health across the population economic growth, and a more harmonious society.<sup>5,9</sup> Economic inequities are not accidental, they result from decisions made by society on issues such as tax policy, home ownership, business regulation, welfare benefits and health care funding.<sup>9</sup>

Inequities in health can be reduced without diminishing the health of the population overall. Universal public health interventions such as sanitation reforms, fluoridation of water, better quality housing, better roads, seat belt laws and food security improve the health status of the whole population. However, there is a need to continue to invest in targeted interventions for disadvantaged groups. Such programs may also benefit the broader community (for example a Women’s Health clinic opened for disadvantaged women as a primary target can be accessed by all women).

Finally, despite growing awareness of affects of inequity on health some public health and health promotion efforts targeted at modifying individual lifestyles may have actually **worsened health disparities** (for example stand-alone media campaigns). Inequities in life expectancy have remained unchanged, or have even widened in recent decades in many countries due to the fact that the affluent adopt healthier lifestyles faster than the less well off, and the net result of individually targeted interventions has increased disparity in outcomes.<sup>9,14</sup>

The reduction of health inequities has a special moral urgency<sup>15</sup> and health promotion as part of the health system should take steps based on professional ethics to play an active role in addressing it. It is necessary for population health services to take action to improve the health of all people, particularly the disadvantaged to reduce the increasing gap in health status.

At a state level, equity in health has been identified in key policy documents including Healthy People 2005 and NSW Health has developed an equity and health policy statement (currently in draft form) to help guide the action.<sup>3,7</sup> In 2001, the NSW Health Promotion Directors Network had also identified equity as a priority for action.

Although addressing health equity is an underlying principle of health promotion practice,<sup>16</sup> many interventions are more likely to reach those of higher socio-economic status. The evidence

for effective equity based interventions in health has been documented and characteristics of success for this work have been described.<sup>17,18,19</sup> However, health promotion in general, grapples with what to do to address inequity due to organisational context issues and practical difficulties of translating rhetoric into practice.<sup>6,19</sup>

*“On the one hand, we have not fully understood the complexity of the problem; neither have we consistently applied all the theory that has been available to us. On the other hand, there has been a lack of political commitment and resources...so that we have not been in a position to truly test the extent to which we could make a difference.”<sup>6</sup>*

The recent increased attention around health inequities research and policy in Australia and overseas, plus the identified need for tools to assist both program development and organisation of services to effectively support this work, has led to this current project.

## **1.2 Project description**

This project was a partnership between Centre for Health, Equity Training, Research and Education (CHETRE), the Health Promotion Service, South East Health and the University of NSW. The NSW Health Centre for Health Promotion and the Health Promotion Service, South East Health funded the project. It was developed and implemented on behalf of the NSW Health Promotion Directors network.

An advisory committee guided the project. It consisted of representatives from Health Promotion (one rural and one urban Unit), NSW Health Department, Women’s Health, Multicultural Health, Community Health, Mental Health, Public Health, Premier’s Department, CHETRE and Corrections Health.

Two project officers, the Director of Health Promotion and the coordinators of research and evaluation and communication and marketing implemented the project. The project partners, CHETRE and the University of NSW provided advice and support during the project development and implementation.

### **Goal**

The overall goal of the project was to improve the way health promotion/population health services in NSW address and support equity-based action at the local and state level.

### **Objectives**

- To identify good practice in health promotion equity based projects;
- To identify current gaps and future opportunities in addressing local and state equity issues.
- To develop tools to assess equity based approaches at organisation and program/project levels

### **Target group**

The project was primarily aimed at health promotion services but was considered to be relevant to other population health services that have an interest in equity.

## **2. Methods**

The following steps were taken:

- Interviews with health promotion practitioners
- Group consultations with population health managers and consumer advocates
- Data analysis and identification of themes
- Tool development and testing

Project implementation was also supported by an ongoing literature review on the nature of inequity in health and effective interventions.

### **2.1 Interviews with practitioners**

In total 12 semi-structured interviews were held with health promotion practitioners from NSW (eight urban and four rural). The projects were selected from the NSW Health Promotion Annual Report 2000 which included Area's highlights. Selection was based on criteria developed by the project working-group (Appendix 1).

The project working group in consultation with the project partners developed the interview guide (Appendix 2). The interview guide aimed to investigate issues around equity focussed health promotion work within the context of interviewee's practice. It covered both organisational and project level barriers and enablers and explored potential strategies to maximise a focus on equity. In particular, it aimed to find out what was specific to equity focused health promotion, and what practitioners would do differently if projects were going to increase emphasis on equity or become equity focused.

The interview guide was piloted with three health promotion officers from South East Health and amended following the pilot. The project officers conducted all interviews either face to face or over the telephone. Interviews lasted on average one hour. All interviews were tape recorded with permission and transcribed by an independent, qualified transcriber. Copies of the transcriptions were sent to all interviewees for confirmation of content and approval.

### **2.3 Group consultations**

Group consultations were held with the NSW Directors of Community Health, Women's Health, Public Health, Multicultural Health, and Aboriginal Health as part of their regular meetings. A one-day workshop with NSW Health Promotion Directors and a half-day workshop with consumer advocates were also conducted. In total, approximately 130 people were consulted. The project and issues raised in the interviews and consultations were also presented and discussed with staff from South East Health Promotion Service and at a Think Tank at the 2002 national Health Promotion Conference.

The group consultations attempted to explore the responses of managers and workers to themes raised during the practitioner interviews, to gauge their support or disagreement and identify new issues. The time frame available for most group consultations was one hour.

The project workers recorded comments made during the group consultations and the workshop general group discussions. Comments made by workshop participants during small group work were noted at each stage of the workshop by a group facilitator. Some parts of the consultation with the representatives of community advocates group were tape recorded with permission and transcribed by the project workers.

## **2.4 Data analysis**

Data analysis was guided by the work of Miles and Huberman<sup>20</sup> and unpublished work of Rosalind Hurworth. It involved sorting the data into categories and identification of most common themes emerging from the interviews and consultations.

The project officers and the Research and Evaluation Coordinator undertook the data analysis. This was to ensure agreement on the resultant themes and summaries. The process was iterative and involved going back to the data for checks for consistency and credibility. The project officers and Research and Evaluation Coordinator conducted the initial analysis independently of each other and then met to compare their findings. They met several times to discuss the emerging themes and confirm support or lack of support for each theme. Information from all types of consultations was ‘triangulated’; quotes from the interviews, comments from consultations and the workshop were compared and assessed for similarities and differences.<sup>20,21</sup>

## **2.5 Tool development and testing**

### **Tool development**

Development of the tool was evolutionary. It involved an iterative process of constantly moving between the research findings, practitioners feed back and literature.

A literature review of health promotion planning models and theoretical models underpinning good practice in health promotion, population health and prevention work was conducted concurrently with the interviews and group consultations.<sup>22-28</sup> Results of this literature review were used to identify generic good practice in health promotion and the development of an initial internal working model.

The findings of the interviews and group consultations were documented and presented to the NSW Health Promotion Directors, staff from South East Health Promotion Service, the project advisory committee and project partners. A workshop with 27 health promotion workers from other Area Health Services and practitioners working in the areas of population health and prevention was held to further inform tool development. Both presentations and the workshop led to further discussions and feedback about organisational requirements and strategies appropriate for equity focused work. The issues identified in the findings and in practitioners’ feedback were incorporated into the working model.

The findings and the feedback were compared and checked against the literature. This resulted in further changes to the model. At the end of the process, the working model evolved into the ‘Four Steps Towards Equity: A Tool for Health Promotion Practice’. (Appendix 3).

### **Testing of the tool**

The contents of the 'Four Steps Towards Equity: A Tool for Health Promotion Practice' was checked against the literature on equity-based interventions to see if it covers the full *range* of strategies that had been identified for good equity focussed work.

An initial draft version of the 'Four Steps' tool was presented to the staff of South East Health Promotion Service and circulated to members of the advisory committee and project partners for comments and assessment. Feedback was used for amending the draft.

A second one-day workshop with 23 health workers was held to obtain feedback on the tool. This workshop included health workers who work explicitly on equity issues or community development, health workers who not usually involved with equity focussed work as well as health workers representing various population-based services. The workshop aimed to test the tool for 'face validity' and acceptability for practitioners. It centred on the content of the tool and the applicability and suitability of each of the steps for population health work. At the end of the workshop participants were given a questionnaire asking them to identify gaps in the tools and propose suggestions for improvements. The notes taken during the workshop and the information provided by participants in the completed questionnaire were reviewed by the project working-group and used to refine the tool.

The refined draft was circulated amongst the NSW Health Promotion Directors, members of the advisory committee, project partners and key experts for final comments. Their comments were incorporated into the final version.