NSW HEALTH

NSW Health and Equity Statement

In All Fairness

Increasing equity in health across NSW

May 2004

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SHPN (PHCP) 040097
ISBN 0 7347 3671 1

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May 2004

Foreword

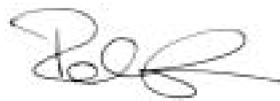
Equity in health is a major goal for the NSW Government. We know that how healthy you are and how long you live is not only related to good medical care and health services, but also to how much you earn, where you live, whether you have a job and whether you are able to access the services you require. Many of these factors are outside the control of any one person or community. Government therefore needs to play a role.

NSW Health is addressing health inequities through the delivery of high quality and accessible health services to all people in NSW, irrespective of where they live or their backgrounds. NSW Health is also tackling this issue by working with the community, other government agencies and non-government organisations to address the underlying social factors that affect health. But we must do more, and focus our efforts on areas where we will achieve better outcomes.

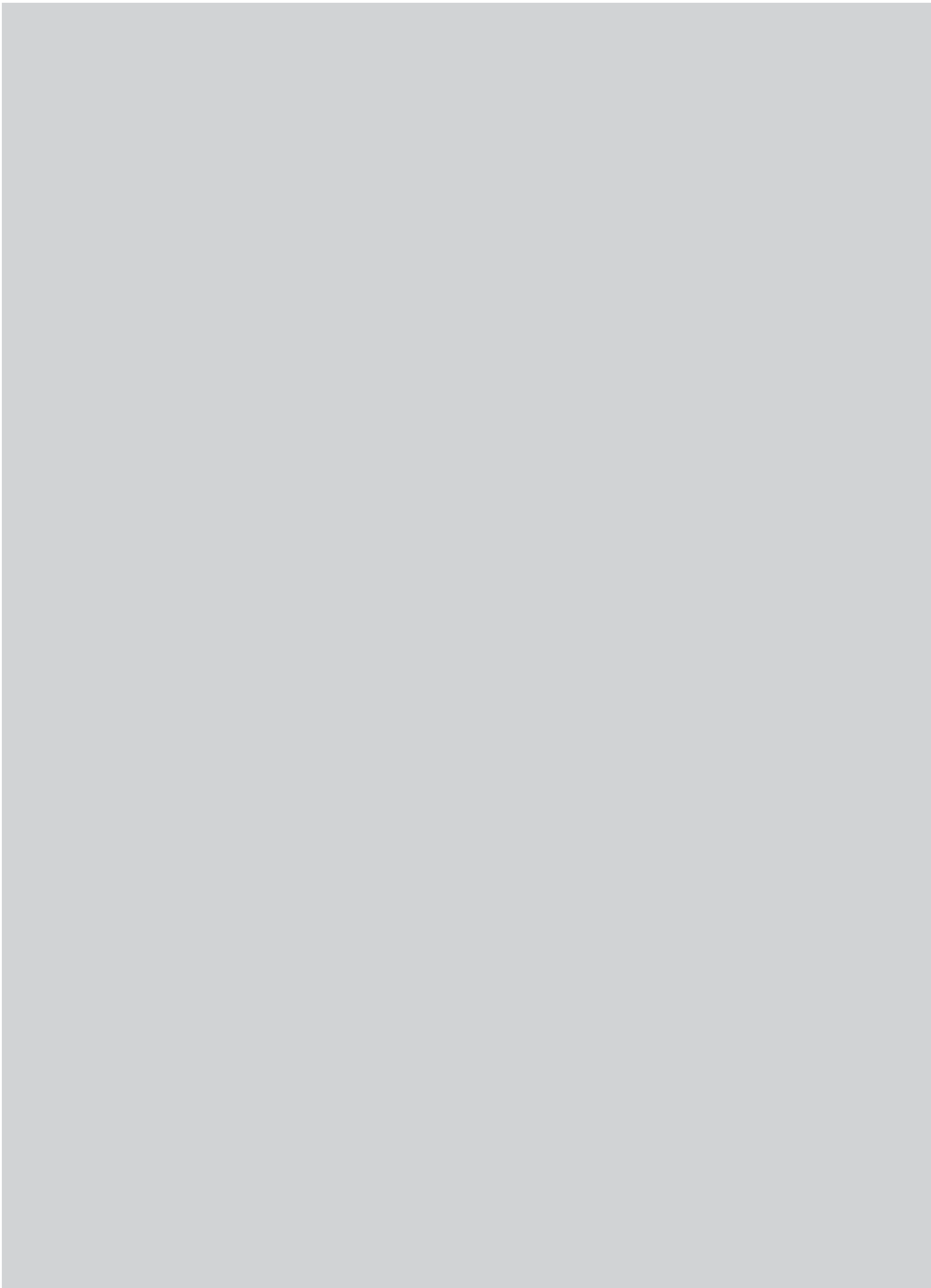
The *NSW Health and Equity Statement – In All Fairness* underpins work already being done, highlights areas warranting particular attention, and provides direction for the NSW health system in addressing health inequities over the next five years.

In summary, *In All Fairness* provides a platform for planning and decision-making about current and future initiatives within the NSW health system. It is consistent with national and international directions and complements other NSW Health initiatives such as *Healthy People 2005* and *Strengthening Health Care in the Community*. *In All Fairness* indicates the NSW Government's commitment to social justice, strengthening local communities and achieving good health outcomes for all.

The Hon Morris Iemma MP
Minster for Health
May 2004



Robyn Kruk
Director-General
NSW Department of Health
May 2004



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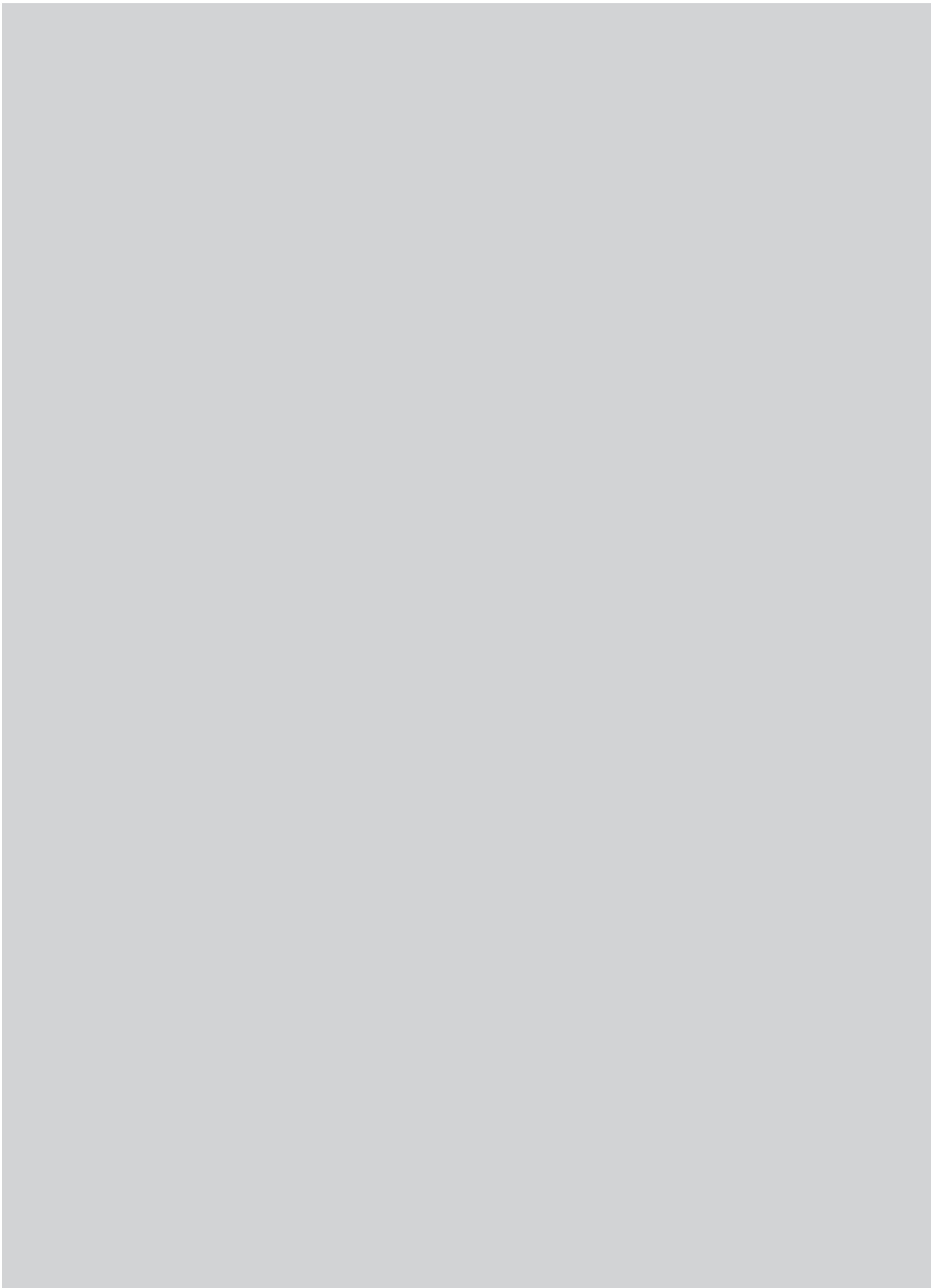


Executive summary

1

The NSW Health and Equity Statement – In All Fairness (*In All Fairness*) recognises that the health gains realised over the past several decades have not been equally shared across the entire population. There remains a health 'gap' between those people with the best and poorest health in NSW, and this has profound implications for the health outcomes of some of the most vulnerable groups in the community. This presents a major challenge to the NSW health system and is the reason for the development of this Statement.

Many of the inequalities in health status occur naturally as a part of the normal life course, such as due to the ageing process, or as a consequence of genetic or biological differences, or lifestyle choices. There is a wealth of evidence to also suggest that some differences in health are due to the impact of a range of underlying social factors on people's everyday lives. Factors such as how much we earn, what our job is and what level of education we attained, clearly have an important influence on our health.

People from the most disadvantaged groups in our community:

- have the highest rates of exposure to risk factors such as smoking, substance abuse, physical inactivity and poor nutrition
- make the most use of primary and secondary health services but the least use of prevention and health promotion services
- are much more likely to die earlier and experience higher rates of illness and disability than people from the least disadvantaged groups.

There are major health inequalities relating to factors such as Aboriginality, socio-economic status, country of birth, rurality and incarceration.

- An Aboriginal boy can expect to live about 20 years less than a non-Aboriginal boy and an Aboriginal girl 18 years less than non-Aboriginal girl.
- A girl living in one of the most socio-economically disadvantaged areas of the State is over six times more likely to have a baby in her teenage years than a girl living in a more socio-economically advantaged area.
- A girl from one of the most disadvantaged rural areas will live 13 years less on average than a girl born in one of the least disadvantaged urban areas.

In All Fairness is not concerned with eliminating all health differences so everyone has the same level of health, but rather to reduce or eliminate those differences that result from factors that are considered avoidable and unfair. The term 'health inequity' refers to differences in health status that are the result of factors that are considered to be potentially avoidable or unfair (eg unemployment), rather than those differences that occur as part of normal life processes (eg ageing).

Why have a Health and Equity Statement?

Equity has been a guiding principle for NSW Health for a number of years. Many initiatives including *Strengthening Health Care in the Community, Families First*, and *Young People's Health: Our Future*, have been developed and implemented to reduce health inequities across a range of health issues and specific population groups. These initiatives have in general been successful in directing attention and resources to the health needs of particular groups. Nevertheless, at a health system level, it is evident the general improvements in population health and life expectancy achieved over time have not been equally shared across the population.

In All Fairness is a point of reference for the NSW health system to gauge current strategic directions, policies and programs in terms of reducing health inequities. It provides a framework for NSW Health to build on the good work that it is already being done, by acting as a platform for future planning and decision-making within the NSW health system to reduce the 'gap' in health outcomes. It also provides a foundation for integrating equity into the core business of NSW Health so that it becomes second nature in practice, in a similar manner to quality and safety.

Key focus areas and strategies for priority action

Key focus areas identified for priority action in reducing health inequities are based on the findings of a comprehensive review of strategies and interventions in Australia and internationally that have been shown to work. These key focus areas are:

1. Strong beginnings: investing in the early years of life
2. Increased participation: engaging communities for better health outcomes
3. Developing a strong primary health care system
4. Regional planning and inter-sectoral action
5. Organisational development: building our capacity to act
6. Resources for long-term reduction in health inequities

The selection of strategies across these key focus areas is based on the evidence of their effectiveness in reducing inequities. The strategies also take into account: the opportunity for achieving 'early wins', intermediate benefits and longer term outcomes; the need to balance high and low-risk actions and benefits; cultural and ethical appropriateness; and the capacity to address the social determinants of health that contribute to inequities in a broader way than a purely clinical intervention.

Health Services are already working to redress inequity of access and outcomes in health status across a range of funded health programs. At the same time, *In All Fairness* requires us to ask whether we are targeting this investment well enough. It provides an important impetus for Areas to review existing local initiatives using an 'equity filter'. The findings of such reviews should inform planning and decision making regarding resource allocation and service redevelopment.

A starting point will be local Health and Equity Profiles developed by Health Services as a part of their Public Health Plans, which will identify areas where action is required. A 'tool kit', *Integrating Equity into Practice – A Strategies Document for Addressing Health and Equity*, which identifies current policies, programs and processes that might be used to implement a particular equity approach, will assist the Health Service response.

1. Strong beginnings: investing in the early years of life

There is growing evidence that individuals who receive a good start in life enjoy significant long-term physical, mental and emotional health benefits. This begins with good maternal health, antenatal and postnatal care and ensuring an environment supportive of healthy development, particularly in the first eight years of life.

As childhood experiences and the influence of families and peers are very important for developing future health-related behaviours, strategies need to be implemented which support mothers, their babies and families. The strategies for this key focus area concentrate on children aged 0-8 years but many also aim to enhance the family and social functioning of mothers and families generally.

2. Greater participation: engaging communities for better health

There is increasing recognition of the value of people participating in decisions about their health and health services. A person's sense of wellbeing is directly related to the quality of their relationships and the amount of control they feel they have over their situation. There are a range of strategies empowering people and communities to identify problems and work together in developing solutions to things that affect their health. Strategies for this key focus area aim to increase the opportunities for individuals and communities to participate in the full range of activities within the NSW health system.

3. A stronger primary health care system

For most people the first point of contact with the health system is the primary health care sector, whether through their general practitioner (GP), a community health centre or a health promotion program in a local shopping centre. There is evidence that those people and communities with the poorest health often have poorest access to health services and make least use of preventive health services. A strong primary health care system is therefore important in reducing levels of health inequity and improving the health status of the most disadvantaged groups in the community.

The strategies for this key focus area concentrate on developing accessible, high-quality primary health care services that are integrated into the health system, as well as making sure these services are available to all people in NSW who need them.

4. Regional planning and inter-sectoral action: working better together

Many of the social determinants of health lie outside the control of the health system. NSW Health must therefore continue working with multiple partners to address these determinants in order to reduce health inequities. Effective collaboration across a range of government and non-government agencies is essential for addressing the wider social factors that influence health, and for developing health services that are comprehensive and responsive to people's needs. Planning and implementing strategies must involve action at all levels, from local communities, to local, regional and state agencies, and the Commonwealth Government. The strategies for this key focus area concentrate on developing integrated planning, service delivery and evaluation mechanisms to encourage collaboration.

5. Organisational development

Efforts to reduce inequities in health must become even more central to the business of NSW Health. Planned improvements in systems and infrastructure are required to assist in building the capacity of the NSW health system to achieve this goal. The capacity to assess whether actions and investments are improving health and reducing health inequities must also be developed at all levels of the NSW health system. The strategies for this key focus area concentrate on ways to facilitate organisational development and capacity building to integrate the pursuit of equity into practice within the NSW health system.

6. Resources

Health disadvantage and inequity develop over many years through a complex interplay of various factors. Sustaining successful strategies for dealing with long-term difficulties depends on establishing realistic resourcing and timeframes. The strategies for this key focus area therefore relate to the promotion of equitable resource allocation over realistic timeframes to reduce health inequities.

Conclusion

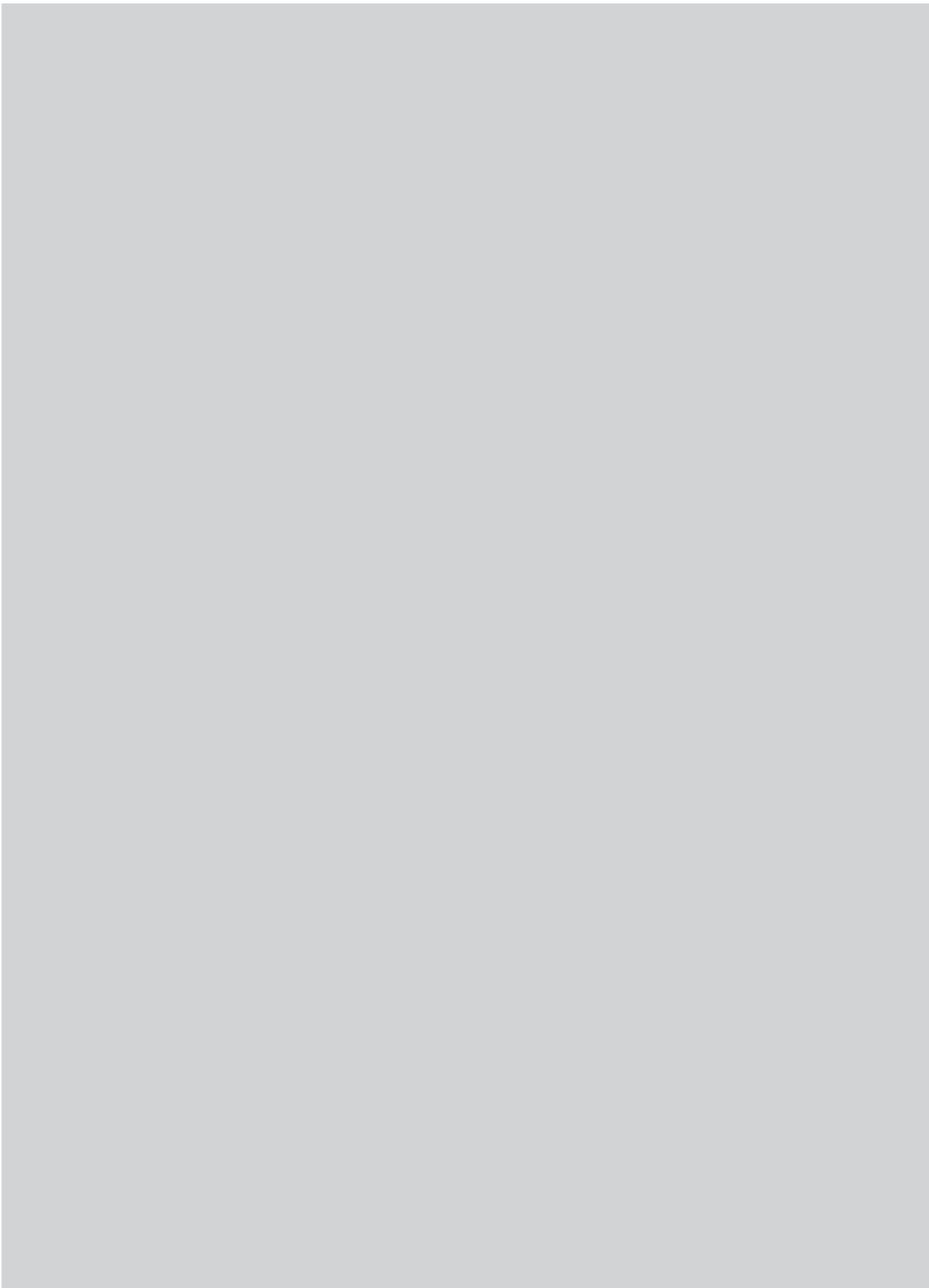
The gaps between the health of the most and least disadvantaged members of the NSW community are persistent and significant, and there is concern that these gaps may be widening. Some of these gaps result from factors that are unnecessary, preventable or at least reducible in their health effect, and this is unfair.

Equity is a core value of NSW Health, and in many parts of the system there are already high levels of action and commitment to reducing health inequities. To achieve equity, system-wide action and new ways of working with each other, with consumers and local communities, and with other government and non-government organisations, is required.

The strategies outlined in this document build on existing efforts. They also recognise that the greatest gains in addressing health inequities are to be made by embedding equity across the health system in ways that will benefit all residents of NSW, and especially people who are most disadvantaged. This will be achieved through a combination of universal and targeted strategies.

The strength of *In All Fairness* lies in the breadth of involvement in its development. It builds on the five priority areas for the socio-economic determinants of health identified in *Healthy People 2005* and other NSW Health initiatives. The proposed strategies emerged from a major consultative and participative process. These strategies will enable the NSW health system to refine and strengthen its capacity to meet the needs of communities and to extend its role and influence as an advocate for equity in NSW.

If NSW Health is to build on the strategies outlined in this Statement and be successful in substantially reducing health inequities, equity needs to be viewed as part of the core business of the NSW health system. Actions to improve equity in health must become routine in the day-to-day work of all health workers and all health services. *In All Fairness* seeks to make a significant contribution to that process.



Introduction

2

People living in NSW generally enjoy good health and have access to some of the best health care services in the world. For many years now governments have recognised the importance of ensuring access to the fundamental prerequisites for good health, such as clean water and air, adequate sewage and waste disposal systems, safe working and living environments, adequate income and access to education and training opportunities.

Continued advances in clinical practice and medical technology have enabled the more effective diagnosis and treatment of many diseases, and have led to us becoming better informed about risk factors for poor health. However, despite significant improvements in the general health of the people of NSW over the last several decades, there is evidence to suggest that these gains have not been equally shared across the entire population.

In All Fairness is concerned with those differences in health outcomes that arise due to a complex interaction of social, economic and environmental factors experienced by certain individuals and groups within our community. The term 'health inequity' refers to differences in health status that are seen as potentially avoidable or at least reducible in their impact on people's health, rather than those that occur as part of normal life processes. *In All Fairness* makes a clear declaration that these health inequities are neither fair nor just in today's society.

Many initiatives already being implemented across NSW aim to reduce health inequities. *In All Fairness* will assist the NSW health system to build on the good work being done and to move forward in reducing the gap between people with the best and poorest health, by:

- increasing the level of investment in the wellbeing of families with young children
- ensuring people from all backgrounds can participate in decisions about their own health, and the development of health services
- developing a strong primary health care system so everyone in NSW can access all parts of the health system and receive the care they require
- ensuring the NSW health system finds better ways of working with other government and non government sectors, particularly at the regional level
- increasing the capacity of the NSW health system to address inequities by improving systems and infrastructure and through workforce development strategies
- ensuring adequate resources are invested over realistic timeframes to reduce health inequities.

In All Fairness provides a clearly defined point of reference for the NSW health system to review and assess its current strategic directions, policies and programs in terms of reducing health inequities. It provides a framework to guide future planning and decision making to enable the NSW health system to reduce the gap between those with best and poorest health, while continuing to improve the health of all people in NSW.

Most importantly, *In All Fairness* confirms that reducing health inequities is core business for NSW Health and outlines the ways in which this issue can be addressed over the next five years. It is recognised that although many of the factors that contribute to health inequities are outside its control, NSW Health also has an important role in advocating for a reduction in health inequities in the broader public policy arena. *In All Fairness* therefore focuses on actions Health Services can take through developing and delivering services and programs, as well as the NSW Department of Health's role in partnership with other organisations, in establishing strategic and policy directions that support the promotion of equity throughout the health system.

The Centre for Health Equity Training, Research and Evaluation (CHETRE) worked with a Health and Equity Project Team (see Appendix A) to develop the framework for *In All Fairness*. This involved extensive

collaboration with a wide range of individuals, groups and government and non-government organisations (NGOs) both within and outside NSW Health (see Appendices A and B). It also included a targeted review of the national and international literature.[1] *In All Fairness* begins with an overview of the rationale for document's development, then examines six key focus areas for priority action, and concludes with a series of strategies for reducing health inequities in NSW.

What is equity in health?

Equity in health is not the same as equality of health status. It is certainly unreasonable to expect that everyone should have the same level of health in any society. Differences in health occur naturally as an inevitable part of the normal life course, such as those arising from the ageing process, or as a consequence of genetic or biological differences, or personal lifestyle choices.

Equity is essentially about fairness. Although it may be thought of in different ways, equity in health is usually understood to be about ensuring equal access to health services for people with equal need, irrespective of personal characteristics such as gender, cultural background or place of residence. While equity in health certainly includes equity of access, it is ultimately about improving equity in health outcomes for those people with the poorest health in our society.

Equity in health implies that ideally everyone should have a fair opportunity to attain their full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition the aim of policy for equity and health is not to eliminate 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 opportunities for health and with bringing health differentials down to the lowest levels possible.[2]

Whitehead, 1990

The concept of 'health inequity' therefore assumes an element of 'unfairness' and suggests that certain differences/differentials in health are unnecessary and may be avoided. It is based on the presence of measurable differences in health across populations and within certain population sub groups that are related to the underlying social conditions that dominate people's everyday lives. They include but are not limited to differences in social, educational and employment opportunities, housing conditions, work conditions, access to nutritious foods, as well as access to health services.

In this document the term 'health inequity' therefore refers to differences in health status that are seen as potentially avoidable or unfair, rather than those that occur as part of normal life processes.

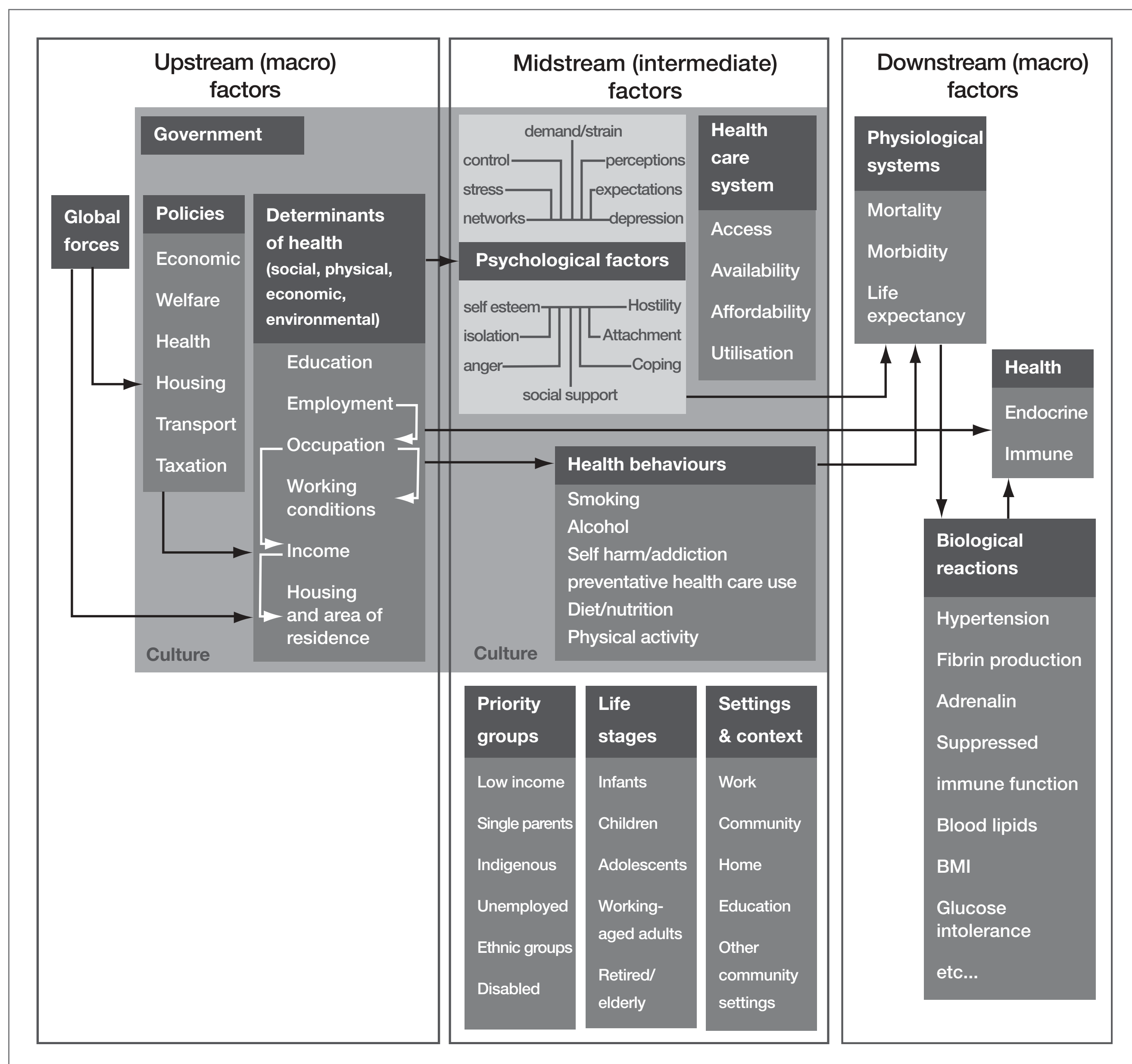
Figure 1 presents a conceptual framework consisting of upstream, midstream and downstream factors for identifying the relationships among many social factors and health. It is generally well accepted these days that the impact of improving access to health services is significantly less than the impact of improving the underlying social determinants of health.

Studies estimate that between 60 to 80% of current disease patterns are preventable through social change and that only a small percentage of premature deaths are the result of inadequate health care.[3]

Brown, 1992

An equity approach to addressing these issues recognises that not everyone has the same capacity to deal with their health problems. It is therefore important to address different people's needs in different ways. Pursuing equity in health involves all efforts both within and beyond the health system aimed at improving life opportunities for people who are most disadvantaged, so that they have the best chance of achieving and maintaining good health. It implies a need for the redistribution of existing and new resources towards redressing these inequities.

Figure 1. A conceptual framework for identifying the relationships between social factors and health. Adapted from Turrell and Mathers, 2004[4]



Queensland University of Technology, School of Public Health (Centre for Public Health Research)

Health inequities in NSW

Linking health and equity is not new.[5,6] The reports of the NSW Chief Health Officer have consistently documented evidence of differences in health related to gender, family composition, education level, employment status, place of birth and place of residence. These are reflected in differences in death rates, levels of illness and disability, risk factors for disease and the use of preventive health services. This is supported by evidence from other countries, particularly the United Kingdom.[7]

The available evidence suggests that certain groups of people may experience disadvantage, which contributes to their poorer health outcomes. Belonging to one or more than one of the following groups does not automatically make someone disadvantaged or more vulnerable to poorer health but, due to the impact of multiple levels of disadvantage, it can increase the risk of poorer health outcomes.

- People of Aboriginal or Torres Strait Islander origin.
- People with chronic mental illness and their children.
- Prisoners and children of prisoners.
- People who are living in communities with little or no access to basic health and social infrastructure, for example, some remote communities, some public housing estates on the urban fringe.
- People with problems related to alcohol and other drugs.
- People on low incomes.
- People who are unemployed, have lower educational attainment, are homeless or in insecure housing.
- Children in care or from families with previous history of statutory interventions relating to child protection issues.
- People with a chronic illness and their carers.
- Refugees and recently arrived migrants.
- People with a disability.

The most recent edition of the *Report of the NSW Chief Health Officer*[8] highlights the major health inequalities in NSW and the nature and extent of some of these inequalities as they relate specifically to Aboriginal and Torres Strait Islander peoples, socio-economic status, and rural and remote populations.

Aboriginal and Torres Strait Islander peoples

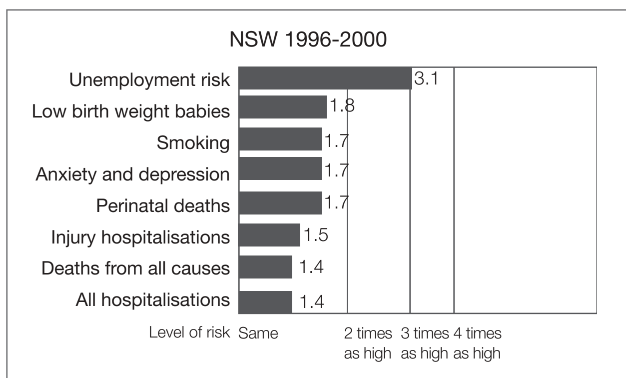
It is widely documented and accepted that the health of Aboriginal people[9] in Australia is worse than that of non-Aboriginal people for almost every health indicator that can be measured.

The evidence clearly shows that Aboriginal people in general die much younger and have a higher percentage of low birth weight babies and children that die within the first year of life than non-Aboriginal people. It is also apparent that this situation has changed very little over the last several decades, despite many policies and programs being developed and implemented to improve Aboriginal health.

The life expectancy for children born in 1998/99 was 56 years for Aboriginal boys (compared with 76 years for non-Aboriginal boys) and 64 years for Aboriginal girls (compared with 82 years for non-Aboriginal girls). Aboriginal boys could therefore expect to live about 20 years less than non-Aboriginal boys and 18 years less for Aboriginal girls.

Figure 2 highlights the extent of social and health disadvantage for selected indicators for Aboriginal people living in NSW.

Figure 2. Indigenous health disadvantage compared with non-indigneous



Each horizontal bar shows the level of risk for the Aboriginal population compared with the non-Aboriginal population for the named indicator. For example, Aboriginal mothers are 1.8 times more likely to give birth to low birth weight babies than non-Aboriginal mothers.

The fact that life expectancies for Aboriginal people today remain similar to those experienced by non-Aboriginal people in the early 1900s is a most compelling indicator of the severity of the situation.

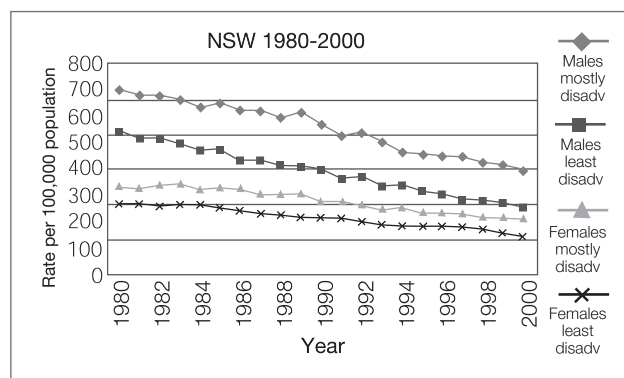
Socio-economic status

Socio-economic status as measured by indicators such as income level, occupation and educational attainment is arguably the strongest and most consistently important factor affecting a person's health status. In NSW and across Australia, inequalities in mortality, morbidity, health behaviours and risk factors are not confined to differences between 'rich' and 'poor' but rather occur across different socio-economic groups.[10,11]

The *NSW Chief Health Officer's Report* suggests that the relative health gap between the lowest socio-economic group and the middle two-thirds of the population appears to be narrowing. However the rate of health gain over the last 10 to 20 years has been much greater for people from the highest socio-economic group compared with those in the lowest group and with the rest of the population.

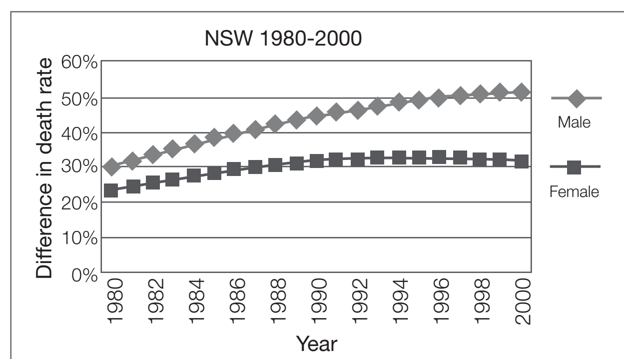
As illustrated in Figure 3, between 1980 and 2000 rates of premature death dropped across all socio-economic groups, by 44% in males and 38% in females. However, this overall decline in death rates has not been shared evenly across different socio-economic groups. Death rates have fallen by 53% for males in the least disadvantaged groups but only by 44% for males in the most disadvantaged groups. Similarly, for females the rates have decreased by 45% in the least disadvantaged groups and only by 37% in the most disadvantaged groups. It is also noted that the overall death rate in 2000 (for both males and females) in the most disadvantaged group was equal to that in the least disadvantaged group more than a decade earlier.

Figure 3. Premature deaths (persons aged less than 75 years) for most and least disadvantaged population quintiles, by sex



The percentage difference in premature death rates between the most and least disadvantaged groups actually increased in NSW for the period 1980 to 2000. Figure 4 shows that in 1980 the premature death rate in the lowest socio-economic group was 24% higher for females and 30% higher for males than in the highest socio-economic group. By 2000 this had increased to 32% higher for females and 52% higher for males in the lowest compared to the highest socio-economic group. In other words the health of the highest socio-economic group is improving at a faster rate than the health of the lower socio-economic groups.

Figure 4. Premature deaths (persons aged less than 75 years) percentage difference between lowest and highest socio-econmic groups, by sex

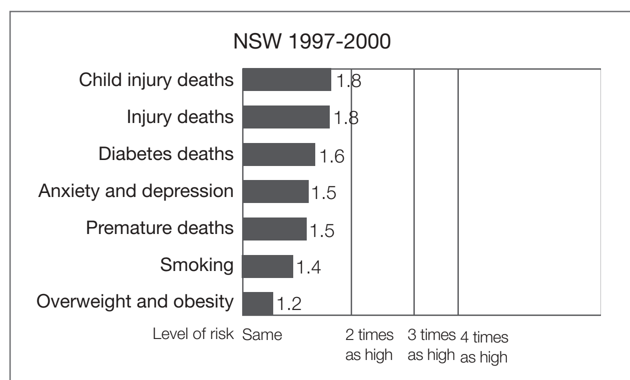


Similar patterns of difference in health related to socio-economic status can be observed for several other indicators of health and wellbeing. Figure 5 illustrates the relative health disadvantage of people in the lowest socio-economic group compared to the highest socio-economic group in NSW. It shows that people in the lowest group have a higher risk of unhealthy lifestyle factors (eg smoking and obesity) and experience poorer health outcomes (eg anxiety and depression) than people in the highest socio-economic group.

A profound difference associated with socio-economic status not shown in Figure 5 is rates of teenage pregnancy. Teenage pregnancy strongly correlates with poorer health and wellbeing outcomes for both mother and baby. The proportion of teenage girls giving birth each year ranges from less than one in 250 teenagers in the highest socio-economic group to more than one in 40 in the lowest socio-economic group.

A girl living in one of the most socio-economically disadvantaged areas of the State is therefore over six times more likely to have a baby in her teenage years than a girl living in a more socio-economically advantaged area.

Figure 5. Health disadvantage of lowest socio-economic group compared with the highest for selected indicators



Each horizontal bar shows the level of risk for the lowest socio-economic group compared with the highest for the named indicator. For example, a child whose family is from the lowest socio-economic group is 1.8 times more likely to die from injury than a child in the highest socio-economic group.

Rural and remote populations

Significant differences in health status exist based on where a person lives in NSW. This difference is particularly apparent between people living in rural and urban areas.

Table 1 demonstrates that in NSW during the 1990s, there were significant differences in life expectancy depending on whether a person was born in a rural or urban area. It also shows that there are differences in life expectancy between different socio-economic groups within both rural and urban areas. The data in Table 1 indicates that boys born in the most disadvantaged rural areas could expect to live 66 years, which is 14 years less than boys born in the least disadvantaged urban areas of NSW.

While girls in all areas live longer on average than boys, those girls from the most disadvantaged rural areas will still live 13 years less on average than girls born in the least disadvantaged urban areas, that is, 73 years in the most disadvantaged rural areas compared to 86 years in the least disadvantaged urban areas.

Table 1. Life expectancy at birth in NSW, 1994-1998

	Area of residence	Boys (yrs)	Girls (yrs)
Rural	Most disadvantaged	66	73
	Least disadvantaged	80	83
Urban	Most disadvantaged	70	79
	Least disadvantaged	80	86

Interestingly, life expectancy is the same for boys born in the least disadvantaged rural areas and urban areas of NSW. There is a four year difference between boys born in the most disadvantaged rural areas compared to boys born in the most disadvantaged urban areas.

Why have a Health and Equity Statement?

Equity has for many years been a major goal for NSW Health. The NSW Health Council reinforced this commitment in its March 2000 report by stating, 'We believe that everyone in NSW should have equitable access to quality health care for comparable need', and by highlighting the 'need to reduce the social, economic and environmental factors which lead to poor health'.[12]

In NSW, many programs and policies have been developed and implemented to meet the needs of specific populations and groups whose health status is poorer than that of the community as a whole.[13] Table 2 lists some of the wide range of initiatives that have been undertaken by NSW Health, which contribute to reducing health inequities. These State-based activities have also occurred in conjunction with others at the national level, such as Medicare, which aims to provide universal access to general practice and hospital care for all Australians.

These initiatives have in general been successful in directing attention and resources to the health needs of particular groups. Nevertheless, at a health system level it is evident the general improvements in population health and life expectancy achieved over time have not been equally shared across the population. Instead what we have seen is that the gap between those with the best and poorest health may in fact be widening.[14,15]

During the past decade there has been growing interest in Australia and internationally in moving beyond describing health differences to taking specific action to reduce these inequities. The United Kingdom, New Zealand, Canada and many European countries have increasingly recognised that there are economic and social justice arguments for redressing health inequalities.[16,17,18] In Australia, there is growing evidence of effective interventions to reduce health inequities, and development of a national research program and policy development agenda.[19]

Table 2. Examples of current NSW Health initiatives that aim to reduce health inequities

- *Strengthening Health Care in the Community Strategy* (2002)
- *Women's Health Outcomes Framework* (2002)
- *Domestic Violence Policy* (2003)
- *NSW Rural Health Plan* (2002)
- *Review of the Health Need Index of the Resource Distribution Formula* (RDF) (2002)
- *Partners in Health Report* (2001)
- *Healthy People 2005: New Directions for Public Health in NSW* (2001)
- *Drug Treatment Services Plan* (2000)
- *Strategic Directions to Advance the Health of Women* (2000)
- *Ensuring Progress in Aboriginal Health: A Policy for the NSW Health System* (1999)
- *The Start of Good Health: Improving the Health of Children in NSW* (1999)
- *Initiatives arising from the NSW Drug Summit* (1999)
- *Caring for Mental Health: A Framework for Mental Health Care in NSW* (1998)

What is clear is that any approach to tackling health inequities must balance universal strategies with those targeting the needs of specific disadvantaged communities. While universal approaches to health care help maintain and improve overall health status, targeted programs can help reduce the gap in health status between groups and focus on those who have the poorest health.

In All Fairness draws from the available evidence of strategies that have been shown to work in reducing health inequities in Australia and internationally. It provides a framework for NSW Health to build on existing policies in shaping future policy directions within and beyond the health system. While *In All Fairness* does not offer detailed responses to the specific needs of particular disadvantaged groups, priority communities should continue to be identified and targeted for programs where mainstream health services are unable to meet their needs.

The purpose of *In All Fairness* is to provide a foundation for embedding an equity approach within the NSW health system and to promote the achievement of equitable health outcomes as core business for NSW Health in a similar manner to quality and safety. It aims to give impetus for real changes in the way health care services, including services that promote and protect health, are planned and delivered in NSW.

Yardsticks for the Statement's success will be measurable changes in the way health services are delivered and, most importantly, a reduction over time in the gap between those people with the best and poorest health outcomes in NSW.

Principles

In All Fairness is underpinned by the following principles

1. Equity in health is a core value that is fundamental to the work of NSW Health.
2. Universal and targeted action must be taken to reduce the gap in health status between those who are most and those who are least disadvantaged, while continuing to improve the health of all people.
3. Action requires long-term commitment and adequate resources.
4. Partnerships with local communities and other Government and non-government organisations are essential for any effective action to address health inequities within the health system.
5. The diverse cultural and linguistic backgrounds of the people of NSW is valued and should be reflected in approaches to program development and service delivery.
6. Evidence of effective action needs to be demonstrated through investing in innovation and regular evaluation of policies and programs.

Key focus areas

The key focus areas for reducing health inequities were identified following a careful analysis of the outcomes of health and equity strategies and interventions both in Australia and internationally and based on feedback on the effectiveness of these and other interventions from individuals, groups and organisations within and external to NSW Health.

Six key focus areas as priorities for action are

1. **Strong beginnings**
   Investing in the early years of life
2. **Increased participation**
   Engaging communities for better health outcomes
3. **Stronger primary health care system**
   The first point of contact with the health sector
4. **Regional planning and inter-sectoral action**
   Working better together
5. **Organisational development**
   Building our capacity to act
6. **Resources**
   For long term improvement in reducing inequalities

Strategic directions

The strategies identified for each key focus area are designed to assist Health Services to incorporate equity into current programs, policies and practice, rather than establishing separate equity initiatives.

The selection of strategies is based on the following criteria:

Addresses the social determinants of health

The strategy tackles the social determinants of health and is broader in outcome than a purely clinical intervention.

Evidence of strategy has an effect on reducing inequities

The strategy has proven successful in conditions relevant to NSW, or shows promise and has a high level of consensus and experience to suggest it may be effective. Alternatively, the strategy may be a new idea based on sound theory and/or the experiences of other sectors and structures in managing similar issues, especially when there is no existing intervention or where previous interventions have failed.

A balance of period and effect

The strategy is either an 'early win' resulting in an immediate outcome and/or will have intermediate to medium-term benefit and/or will have longer term outcomes.

A balance between risks and benefits

The strategy balances actions that are high-risk and high-gain or low-risk and high-gain.

Appropriateness in terms of culture, ethics and community focus

The strategy is culturally and ethically acceptable and appropriate to the situation and/or target group, has been designed in consultation with the target group, and is designed to empower and operate in partnership with the target group.

A starting point will be local Equity Profiles developed by Health Services as a part of their Public Health Plans, which will identify areas where action is required. A 'tool kit', *Integrating Equity into Practice – A strategies document for addressing health and equity*, which identifies current policies, programs and processes that might be used to implement a particular equity approach, will guide the Health Service response.

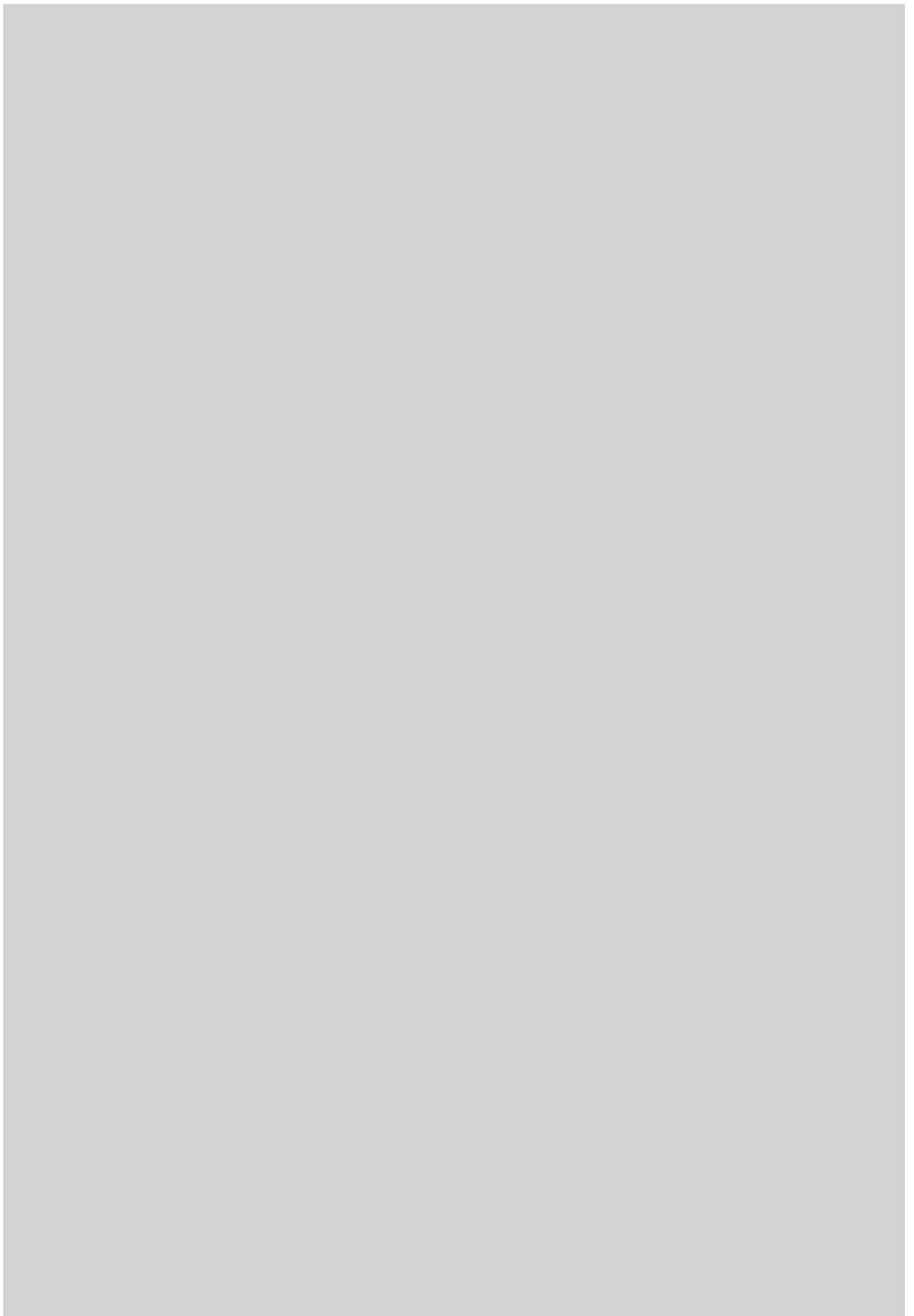
Informing the development of *In All Fairness*

A Project Management Committee and two Reference Groups were established to provide management and input to *In All Fairness*. Members included senior executives and representatives from the NSW Department of Health and Health Services, other NSW government agencies and NGOs. Technical Working Groups established from the membership of these groups and other nominations, were responsible for developing input on specific focus areas for inclusion in the Statement.

A Targeted Literature Review was conducted to identify the range of health and equity interventions available and the evidence about the outcomes from these interventions. The statements in this document are supported by the findings of this review.

Information obtained by the Literature Review was supplemented by the findings of Health and Equity Workshops held with senior executives from NSW Department of Health, other human service agency executives, Health Services, and representatives from peak NGOs. The representative nature of these groups and workshops provided a mechanism for verifying current findings in the literature about the effectiveness of interventions, as well as identifying interventions that were effective and either not represented in the literature reviewed, or not documented anywhere in the literature.

The Targeted Literature Review and NSW Health and Equity Workshops Report are important companion documents to *In All Fairness*. In addition, *Integrating Equity into Practice – A strategies document for addressing health and equity*, will provide a 'tool kit' in assisting NSW Health to better develop services to reduce health inequities.



Key focus areas 3

1. Strong beginnings: investing in the early years of life

Goal

To secure good health outcomes for children at birth and throughout their lifespan by concentrating on health care during the antenatal period and the first eight years of life.

Discussion

It has been demonstrated consistently in Australia and around the world that individuals who receive a healthy start in life, beginning with effective maternal health and antenatal care, enjoy significant long-term physical, mental and emotional health benefits.[20,21,22]

The health sector has a major role in advocating for and responding to the needs of children, through initiatives for improving the scope and coordination of prevention and early intervention programs. To be effective, these initiatives need to be complementary and to promote a holistic view of health that involves tackling various aspects of the complex interactions between children and their families and their social, economic and cultural environments.

In NSW various policy initiatives are already in place to promote the health and wellbeing of children and ensure good beginnings for infants, young children and youth. For example:

- The Start of Good Health: Improving the Health of Children in NSW (NSW Health's Child Health Policy) 1999
- Young People's Health: Our Future (NSW Health's Youth Health Policy) 2000;
- Families First (NSW Government's policy framework for supporting families with young children) 1999; and
- NSW Health Centre for Mental Health initiatives, for example, Integrated Perinatal and Infant Care Program, Parenting Program for Mental Health, NSW Child and Adolescent Mental Health Strategy and NSW School-Link Initiative.

These policies aim to reduce inequities in the availability of and access to the range of health services appropriate to the needs of children with the poorest outcomes while continuing to improve the health of all children. These examples highlight the need for both universal strategies that maintain and improve the overall health status of children, and targeted actions to improve the significantly lower health status of some children within the community.

The NSW Parenting Program for Mental Health

The NSW Parenting Program for Mental Health is a five-year initiative of the Centre for Mental Health and Western Sydney Area Health Service. The program is coordinated centrally and implemented at the local level by Area Mental Health Services through Area parenting positions or their equivalents. The aim is to develop a coordinated and comprehensive approach to implementing parenting programs that enhance mental (emotional and behavioural) health, with a focus on pre-school aged children.

A key component of the program has been training in the delivery of Triple P (Positive Parenting Program). In 2000-02 more than 1,100 workers were trained in the delivery of Triple P and over 4,000 parents attended programs throughout NSW. Preliminary results show improvements in parenting practices and reductions in behavioural problems in children. This program is useful for high-risk families with 50% of parents enrolling in the program reporting clinical levels of behavioural and emotional problems in their children.

The *Start of Good Health* increased the focus of the NSW health system on developing strategies to improve the health of children through better coordination, collaboration and partnerships both within the health sector and between health and other sectors. The program acknowledges that a focus on enhanced family and social functioning can work to protect children from abuse and neglect. Specific programs based on home visiting, developing community networks and interagency referral

approaches have been shown to be effective in identifying families at risk (to provide intervention before abuse or neglect occurs) and also as crisis management and amelioration strategies.

The NSW Government's Families First Strategy built upon this initiative. Families First illustrates the importance of broad based interventions that assist children, young people, families and communities in terms of reducing health inequities. This particularly includes those who are vulnerable and therefore need specific targeted programs to assist in addressing the social issues that can lead to family dysfunction and which can contribute to poorer health in later life.

Home visiting is an important part of the Families First strategy. Short-term outcomes from home visiting by trained nurses include higher breastfeeding rates, higher immunisation rates, less child abuse and neglect, fewer emergency department visits, and benefits for subsequent children in families that participate in these programs with their first child. The longer-term outcomes (over 15 years) include lower rates of child abuse and neglect, lower rates of substance abuse, lower rates of crime and greater participation in the labour force. Universal home visiting is already being implemented in many areas across the state and sustained home visiting is being considered in a number of specific areas.[23,24,25]

Specific groups that may require targeted strategies include the children of prisoners, children of intravenous drug users, children in care/foster care, children of parents with a mental illness and pregnant teenagers. The *United Kingdom's Independent Inquiry into Inequalities in Health Report* (1998)[26] recommended that local authorities identify and address the physical and psychological health needs of children in care. These children often move from one carer to another, leading to fragmentation and delays in meeting their educational and health care needs, and often do not have the benefit of a professional advocate for their cause.

Families First on the Mid North Coast

Mid North Coast Area Health Service has participated in the NSW Government's Families First initiative since early 1999. This involves a coordinated strategy for increasing the effectiveness of early intervention and prevention services that help families raise healthy, well-adjusted children. The following local service priorities were determined in the context of the Families First framework and resources.

- Specific strategies for Aboriginal communities (developed in consultation with the communities and Aboriginal services).
- Developing a home visiting services networkof professionals and volunteers.
- Providing timely services for children 0-3 years and their families.
- Offering health visitors to families with new babies.
- Developing outreach services for high-risk groups (eg teenage mothers) in particular locations.

Strategies were developed to address social isolation in all locations, starting with identified high-risk areas.

Aboriginal home visiting program in South West Sydney

Tharawal Aboriginal Corporation and South Western Sydney Area Health Service are working together to achieve better outcomes for Aboriginal families in Macarthur by providing culturally appropriate outreach services to all Aboriginal pregnant women in the area. A home visiting team provides care and support for women antenatally and postnatally, which offers an opportunity for early intervention and prevention. The program has a community development focus and is funded for a community development worker (and bus) to work on issues raised by local women. Parenting groups are being developed to promote access to a range of local services, including immunisation, drug and alcohol services, and mental health services. Referrals to these and other services can be arranged for not only the mother and newborn but also any household or family members.

There is also a need for a greater focus on strategies and programs targeting specific health and health-related outcomes. These outcomes include:

- increased immunisation
- prevention and treatment of sexually transmitted infections (before and during pregnancy)
- maternal smoking cessation (before and during pregnancy)
- maternal cessation of other drug and alcohol use (during and after pregnancy)
- more successful and longer-term breastfeeding
- better nutrition of both mothers and babies.

Such 'downstream' strategies and programs aim to improve the health outcomes for particular groups of mothers, infants, babies and/or children who have not accessed or benefited from universal programs in these areas. The literature review found that while universal immunisation programs are successful, the immunisation rate could be further increased by specific strategies that target those who do not seek immunisation.

The Healthy Children's Program

Funding from the NSW Drug Summit has enabled the Western Sydney Area Health Drug & Alcohol Services, in collaboration with the Children's Hospital at Westmead, to develop a program for children whose parent(s) are receiving treatment in the Area's methadone program. The Healthy Children's Program, located within the methadone clinic, provides access to nursing and clinical services, including medical care, parenting and nutritional advice, and immunisation. The location of the Program at the methadone clinic provides children and their parents with easy access to these services in a non-threatening and familiar atmosphere where the children's general health can be checked, they can be linked with appropriate child health services, and their parents can be advised on nutrition and parenting.

Two areas identified for specific action to reduce health inequities are oral health and nutritional status, both of which are affected by socio-economic disadvantage.

Dental cavities are more prevalent in children from lower socio-economic backgrounds. The Save Our Kids Smiles Program 1996 found that the proportion of children whose teeth were free of decay in 1997 and 1998 varied from 76% in Northern Sydney Area Health Service to 56% in Far West Area Health Service.[27]

Better access to nutritious, and affordable high-quality food is critical to improving maternal nutrition before conception, during pregnancy and after birth. This will in turn increase birth weights and improve childhood growth and healthy development. The goal of food security for people in NSW is about ensuring access for all people at all times, regardless of financial status, to the food needed for a healthy life.

This is a significant issue for young mothers and families on low incomes. Families that rely solely on social security payments for income can experience long-term food insecurity, potentially leading to underweight in their children and underweight or overweight when they become adults. Children of women who are underweight or overweight are at greater risk of developing chronic conditions in later life such as non-insulin dependent diabetes and coronary heart disease.

Food insecurity

Consistent food insecurity results in poor nutritional health, which has the potential for profound long-term effects on a person's health, lifestyle, activity level, ability to find work, well-being and lifespan. The problem of food insecurity in our communities is its invisibility. In 2001 parents from poorer areas in NSW were three times more likely to report that they had run out of food, and could not afford to buy more, than parents from wealthier areas (10% compared to 3%). Issues of food insecurity are being taken up in several Area Health Services including Western Sydney, Wentworth and Northern Sydney.

Another way to address the broader determinants of health is through ensuring a comprehensive range of services linked to family support and neighbourhood development strategies. This is already happening in NSW through initiatives such as the Moree Community Midwifery Program, which uses social and other support services to provide Aboriginal women with holistic care before, during and after pregnancy.

These services include making sure that young women have a bank account, adequate housing, clothes for the baby and access to other health services such as a Pap smear. The program works with local GPs, Aboriginal Corporations, Aboriginal Medical Services, other health services and government agencies including NSW Department of Education and Training, and NSW Department of Housing.

NSW Health must take a leading role in advocating and providing evidence about the influence of these socio-economic factors on health in the early years and in later life to other relevant agencies, particularly the NSW Department of Education and Training, NSW Department of Housing and the NSW Department of Community Services. This will promote collaboration in developing policies and programs within 'non-health' areas that are capable of promoting and protecting health, and avoiding the perpetuation of poor health outcomes.

The success of these approaches to comprehensive service planning and delivery depends on a capacity to use funding flexibly between different human service agencies. A recommended strategy is for a pilot program with funds pooled from the human service agencies and conducted within a selected Area Health Service, to develop a comprehensive and innovative approach to service planning and delivery for local children and their families.

The strategies for this key focus area concentrate on children aged 0-8 years. However, many of the strategies are designed to enhance the family and social functioning of mothers and families generally.

2. Greater participation: engaging communities for better health

Goal

To invest in and strengthen community participation in the NSW health system in recognition of the value of individual and community involvement in managing health problems and developing health services.

Discussion

Participation is critical to any strategy that seeks to address health inequities. The evidence consistently demonstrates that engaging people in decisions about their health leads to better health outcomes. All stakeholders in the NSW health system, including consumers, carers, volunteers, NGOs, industry and professional organisations, health professionals, and NSW Health must be given opportunities to contribute to the planning, development, implementation and evaluation of health processes and services.[28,29]

Participation contributes to better health outcomes by empowering individuals and communities to take action to improve their health, and ensuring health services meet individual and community needs. Table 3 outlines the different ways that participation can contribute to better health outcomes.

Table 3. Contribution of participation to better health outcomes

Individual	Community	System
■ Increases the involvement of patients and carers in decisions about their health. ■ Improves quality of care. ■ Improves patient satisfaction. ■ Improves accountability (and focus on rights and responsibilities).	■ Leads to more appropriate, more responsive services ■ Improves accountability (and focus on rights and responsibilities). ■ Increases capacity and social capital. ■ Leads to better health outcomes (population health focus).	■ Legitimates programs and services in building a political constituency. ■ Improves accountability (and focus on rights and responsibilities). ■ Leads to more responsive, more flexible services. ■ Improves skill development and capacity.

The wider community has a strong interest in the quality and range of health services available. Greater involvement in health services will increase community understanding of the way the health system operates and the range of actions needed to improve the health of the population. Increased community participation offers benefits for all parties, including patients, health care providers and the health care system as a whole.

Despite significant efforts to increase the responsiveness of health systems to the diversity of consumers, many groups are still not receiving appropriate services in all circumstances, and are not yet being consistently and effectively included in consumer participation processes.

These groups include:

- Aboriginal people
- people living with a chronic illness, including mental illness
- people from culturally diverse backgrounds who may also have language and literacy problems
- socially or geographically isolated communities
- people with lower levels of literacy.

The NSW Health Council recognised the importance of participation for the health care system. The report of the Consumer and Community Participation Implementation Group established under the *Government Action Plan for Health, Partners in Health: Sharing Information and Making Decisions Together* (2001),[30] informed discussion in the development of *In All Fairness*. During consultation, chief executive officers, workshop participants, technical working groups and the literature review all identified community participation as a key component of any equity based strategies. Three major issues were identified:

1. People whose health is most vulnerable need to be involved in decisions at all levels in the health system as patients and as members of their community.
2. The health system needs to make sure that its participation mechanisms genuinely facilitate participation, and do not act as barriers.
3. It is important communities see tangible outcomes from being involved in consultation and participation processes.

To address these issues effectively, patients and the community must be able to become involved and the health system must be willing to listen and change. Effective leadership will be needed at all levels of health services and systems to:

- encourage clinicians to relate to patients and their carers in a manner that promotes their involvement and awareness of issues affecting the patient's health
- improve levels of understanding of attitudinal and cultural issues that may impact on service delivery
- promote an understanding of the legitimate and important role of participation within the management and development of health services.

Planning together for health in New England

Community participation is a key factor in the development of health service plans in New England Area Health Service. The Area Health Service Board has appointed to Health Service Advisory Committees representatives from the 23 communities in the Area with a hospital or community health centre. Members of each community are invited to public meetings held at various stages of the planning process to help outline the health needs of their community and to inform the development of service plans for these localities. The individual Health Service Advisory Committees are key contributors to Health Service Plans. In addition, there are three Health Councils that actively participate in making decisions about health service planning, policy development and setting of priorities for the Area Health Service.

The NSW Aboriginal Health Partnership

The NSW Aboriginal Health Partnership was formed in 1995 through an agreement between NSW Health and the NSW Aboriginal Health and Medical Research Council – the peak body for Aboriginal Community Controlled Health Services in NSW. The Partnership aims to ensure the expertise of Aboriginal communities is brought to the health care process through development of agreed positions concerning health policy, strategic planning and broad resource allocation issues for Aboriginal health. The State Partnership Agreement requires Area Health Services to establish a Partnership Agreement with each Aboriginal Community Controlled Health Service in the Area in order to put into practice the strategic directions established by the State-level partnership. This initiative has enhanced opportunities for communities to be involved actively in decisions that seek to restore and improve physical, social, emotional and cultural well-being.

The establishment of a common understanding and shared vision of the importance of consumer and community participation is fundamental to making equity a core value of NSW Health. The capacity this provides for the creation of mechanisms to involve people in their own health care and health system development is demonstrated by the role played by Aboriginal Community Controlled Health Services in promoting community ownership and control over health related decisions for Aboriginal people.

Identified mechanisms for involving patients and carers in direct service delivery are important to ensuring services are adequate and responsive to their needs. It is also important to develop specific strategies for engaging members of those groups of people whose health is most vulnerable so that the experiences of the group can be better understood and acted upon.

Consumer Consultant Programs in Central Sydney Area Health Service

Central Sydney Area Mental Health Service has established a consumer consultant program at Rozelle Hospital and within the community. The hospital program established in 1993, involves development of a training package for people who had personal experience of mental illness to provide support to others affected by mental illness. The hospital employs eight part time consumer consultants working a combined 104 hours per fortnight to visit wards, liaise with, and support both patients and staff, provide positive role models for patients and attend patient care and quality improvement meetings. Regular educational sessions are also conducted within the wards. In the community, three part time consultants together working sixteen hours per week support consumers living independently, and work co-operatively with staff in providing rehabilitation programs.

Both programs have co-ordinators who work an average of twenty hours per week. The Area Health Service also employs a full-time Area Consumer Initiatives Officer who is an integral part of the management team. An essential qualification for employment in these programs is that the person has either had or currently lives with a mental illness. The consumer consultants have developed and are now working within a *Consumer Initiative Programme Strategic Plan 2002-2006.*

Health advocates play an important role in helping Health Services take up equity issues by giving the health system feedback on the key concerns of consumers and marginalised communities, and providing structures and support so consumers can participate more effectively in consultation and decision-making processes. Health advocates may be people with a personal interest in a health issue, carers of people with health problems, community groups, professional organisations and NGOs.

There are also specialist health workers such as Multicultural Health Workers who play an important role in ensuring people from diverse cultural backgrounds are involved in the planning and delivery of health services. This is particularly important within refugee and newly arrived immigrant communities and in emerging communities that lack a developed infrastructure.

A key issue raised in the health and equity workshops was the need to overcome isolation and poor communication systems by providing opportunities for exchanging ideas specifically between Health Services and NGOs. As well as leading to new partnerships in health, participation can provide the additional benefit of more and better opportunities for communication between the government and non-government sectors.

A complex response is clearly required to increase patient and community involvement in delivering and developing health services and in taking actions that will improve their own health. Different models of participation will be required at different stages of service development and planning, and for different groups or populations. These models could range from consultation with stakeholders to the community's active involvement in the control and direction of health services. Such involvement could be achieved by collaboration with patients and carers, community representation on committees and through the work of consumer groups and advocates.

Participation at different levels of the NSW health system

The Health Participation Council was convened in March 2003 to advise the Minister and NSW Department of Health on consumer and community participation issues. The Council provides one way for community members to have a say in decisions about the NSW public health system. Area Health Service Boards are responsible for ensuring community involvement in the planning of local health services. This is promoted by a combination of formal structures to encourage and facilitate ongoing participation such as rural Health Councils and Consumer or Community Forums, consultative committees such as Quality Councils, and consultation with consumers and communities on specific issues as they arise.

The Partners in Health report identified several models to address community participation. These models will need to be adapted and refined to ensure participation of the most vulnerable and disadvantaged groups. Potential barriers to participation, such as transport, childcare, language issues and the location and timing of meetings, will require further consideration. To become an integral component and function of the health system, community participation will need to be appropriately resourced both within the health system and in relation to consumer advocate groups and local communities.

The strategies for this key focus area concentrate on increasing the level and range of opportunities for individuals and communities to participate in the full range of activities within the NSW health system. This applies especially to people from disadvantaged backgrounds.

3. Developing a stronger primary health care system

Goal

To improve the accessibility and effectiveness of the primary health care system, particularly for those people with the greatest health needs.

Discussion

Primary health care has been conceptualised in several different ways. The Australian Health Ministers' Advisory Council has defined primary health care in the Australian context as follows:

> *Primary health care seeks to extend the first level of the health system beyond sick care to the development of health. It aims to focus on the health system's first level of contact, on protecting and promoting the health of defined communities and on addressing their individual and collective health problems at an early stage. Primary health care services involve continuity of care, health promotion and education, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology.*[31]

In relation to the health system as a whole primary health care is seen in different ways, as demonstrated by the following descriptions:

- The 'front end' of the health system – for most people, it is their first point of contact in relation to their health.
- The most visible and commonly used part of the health system, accessed by 90% of Australians in any one year.[32]
- The gateway to the secondary and tertiary sectors of the health system.
- Involves care delivered by GPs, nurses, allied health professionals, pharmacists, dentists, community health services, emergency departments, community and non-government organisations, and health organisations controlled by the Aboriginal community.
- Often involves a multidisciplinary approach.
- Often involves a whole-of-community approach.
- Is concerned with health promotion, illness prevention, early detection and intervention, as well as treatment and rehabilitation services.

There is growing evidence that countries with a strong primary health care system have lower levels of health inequity, and that programs with a strong primary health care focus disproportionately benefit people who are most disadvantaged.[33,34]

A comparison of the health systems in 12 western industrialised nations indicates that those countries with a strong primary health care sector are more likely to have better health levels and lower costs.[35] In particular, the advantages of a strong primary health care system are greatest for infants and children.[36]

Despite the evidence, however, investment in primary health care in Australia has remained static in recent years. Although the proportion of recurrent health funding spent on non-institutional medical care increased from 18.4% to 19.3% between 1989/90 and 1997/98, Australia wide, the proportion of recurrent health funding spent on community and public health services decreased from 5.6% to 4.8% during the same period.[37] Within NSW Health, the current data collections provide an unreliable estimation of spending at Health Service level although information technology system developments are beginning to address this issue.

It is widely acknowledged that the acute care system has little capacity to influence the upstream determinants of poor health. The potential for the primary health care system to address health inequities is evident from the findings of the Vinson study, *Unequal in Life*.[38] Individuals and communities with the poorest health often have the worst access to health services and make the least use of preventive health services (the 'inverse care law'). For example, disadvantaged communities in rural and urban areas that have poor health also have fewer GPs than more advantaged areas.[39] Similarly, disadvantaged individuals who are unable to pay for these services are most heavily affected by the continuing decline in bulk billing by GPs.

GPs and community health services working together in disadvantaged communities

A pilot program to co-locate primary health nurses with GPs in two disadvantaged communities in South Western Sydney has been operating since 2000. Preliminary evaluation has shown an increase in the number and range of referrals by general practitioners to community health services. All patients and project staff have reported beneficial outcomes from these closer working relationships.

The current primary health care system in NSW is highly fragmented. In many parts of the State, there is little integration between GPs, community health staff and other primary health care providers, or between these services and other community-based health services and hospitals.

International reforms such as Primary Care Trusts (United Kingdom) and Primary Care Organisations (New Zealand) have sought to improve integration of care through the development of partnerships, enhance the involvement of consumers and carers in health care planning and forge partnerships, both within the health care system and with other government agencies. Within Australia, inter-sectoral initiatives such as the Coordinated Care Trials (Commonwealth and State Governments, including the NSW Government)[40] and the Working Together in the North Coast project[41] have been shown to contribute to improved health status.

Other primary health care interventions shown to improve health status and which are consistent with other key focus areas in this Statement include integrated planning,[42] measures targeted at disadvantaged/at-risk groups and communities[43,44] and community participation in health care.[45]

NSW Health is committed to building a more integrated and responsive primary health care system. *Strengthening Health Care in the Community*[46] released in May 2002 as part of the NSW Government Action Plan for Health provides a statewide framework for improving the structure, planning and delivery of health care in the community. This strategy reflects a broad view of primary health care including a focus on addressing the health problems of local groups and communities, and has a strong emphasis on equitable service provision. There are several initiatives that will improve the accessibility and effectiveness of the primary health care system.

First, Area Health Services have been asked to:

- **Undertake strategic planning for primary health care services** that identifies clear directions for the development of local primary health care services, and which are in turn supported by specific, equity-based strategies for achieving goals and directions.
- **Define and apply a model of care for primary health care,** which specifies the core range and level of services that can reasonably be expected in their communities, including, for example, community nursing, therapy services, mental health, drug and alcohol, early childhood, and child protection services; and
- **Work towards an optimum mix of investment in health care.** If we are to improve the capacity of the health care system to meet demand, specific resources will need to be found to strengthen community-based prevention, health promotion, early intervention, management and rehabilitation.

Second, the NSW Department of Health is working with Area Health Services and other key stakeholders to establish Primary Health Care Networks for coordinating and integrating the provision of primary health care services to geographically defined populations. The overarching purpose of these Networks is to build effective partnerships for inter-sectoral action to address both the immediate and the underlying issues impacting on the health of the local community. They provide a mechanism to develop the structures and processes needed to deliver an accessible, high-quality, integrated primary health care system that is vital to the task of reducing health inequities. Community participation is also central to the development and successful operation of these Networks.

A strong primary health care system must be seen as an investment in community health and wellbeing, with Area Health Services allocating a proportion of their budgets to integrated planning and service delivery within disadvantaged communities. At the same time, there may be a lesser range of services available to these disadvantaged communities. Health Services, and particularly primary health care services, must become more accessible and proactive in meeting the needs of the local community.

Delivering primary health care services in a remote area

Far West Area Health Service's innovative primary health care model for health service delivery in remote sites has been developed to address the difficulty of providing all communities with equal access to a minimum level of health care. This community-centred model includes:

- A primary health care team at each site involving a GP, a registered nurse and Aboriginal health workers.
- Specialist workers (eg Specialist Women's Health Nurse) at four of the larger centres, with a referral and resource role for the primary health care teams.
- Visiting services by medical and clinical specialists (eg endocrinology and paediatrics).

This model aims to ensure that all communities receive good generalist care, and that individuals who need more specialised treatment are referred appropriately with as little disruption to their lives as possible.

The NSW health system also has an important role in working with other agencies and NGOs, and with communities on issues that the communities have identified as important, in delivering better-integrated, more comprehensive services. For example, Health Services may be interested in working with the local police, housing office, neighbourhood centre and women's centre so women who experience domestic violence can be assessed by one service provider for access to housing support, or with the community in improving access to fresh food or transport, or setting up a playgroup.

Co-location of ambulance and health services

NSW Health and the Ambulance Service of NSW are working together on an initiative within the strengthening Rural Health in Smaller Towns program. The initiative aims to develop multi-purpose health centres where the Ambulance Service and other health services are located within one complex. The centres offer a range of health services, and the Ambulance Officers will be trained to meet the local community's identified needs.

The strategies in this area concentrate on developing accessible, high-quality primary health care services that are integrated into the health system, as well as making sure these services are available to all people in NSW who need them.

4. Regional planning and inter-sectoral action: working better together

Goal

To increase the capacity of the NSW health system to work with other sectors to address health inequities through improved regional planning and inter-sectoral action.

Discussion

The major diseases that contribute to ill health in NSW are well known, and many of the major behavioural and environmental risk factors for these diseases are well described. In many countries, this information has provided a rationale for setting national and state-level health priorities. In Australia, the six national health priority areas which have been identified are cardiovascular health, cancer control, injury prevention and control, mental health, diabetes mellitus, and asthma.[47]

NSW Health has developed a range of responses and strategic plans to address these national priorities, according to the available evidence for best practice in public health protection, promotion and health care services. But like many other health systems, NSW Health has not been able to achieve a significant reduction in the gap between people with the best and poorest health. This ongoing deficit is explained partly by the fact that many social determinants of health lie outside the control of the health system.

Addressing the social determinants of health has not been a strong feature in traditional health systems that focus on the treatment of disease. The relevance of these social determinants to health priorities and health action planning has been recognised internationally, notably in the United Kingdom and New Zealand, as well as in Australia. There is now compelling evidence that efforts to address ill health and health inequities cannot succeed unless the social determinants of health are also given priority. This requires NSW Health to work more effectively and collaboratively with a wide range of other government and non-government agencies beyond the health sector.

> *'It cannot be assumed that social initiatives taken at the state or national level, can override extreme degrees of local cumulative disadvantage. Indeed if the residents of such localities and their children are to break free from this web of disadvantage which limits their life opportunities, intensive help in the form of education, health, family support, housing, justice and other needed community services is required, in combination with supported community-building endeavours to sustain the benefits of assistance rendered.'*
>
> **Vinson, 1999**

This is consistent with the evidence from the literature review, which found that projects designed to reduce health inequities should also seek to tackle unemployment, poor education, poor housing and inadequate income. Projects that have contributed the most to improving health status invariably involve inter-sectoral collaboration, a capacity building approach and effective communication networks.

Miller Strategy

A Multiagency Taskforce formed by the Minister for Police examined crime and other social problems in Miller, a suburb of Liverpool in South Western Sydney, in 2001/2002. This strengthened the work undertaken by Community 2168, a partnership between the Community, Liverpool Health Service, Liverpool City Council, NSW Department of Housing, NSW Police, and NGOs to improve the health and well-being of the community.

Establishing the 'HUB' in a former post office building in Miller Square was a success story of Community 2168. The central location made the HUB an ideal base for providing government and community services information, outreach service delivery and community development, as well as a space for community activities. The Taskforce's recognition of the HUB's success resulted in funding for the purchase of the property. This secured the HUB's role in the community and increased community confidence that the agencies have made a long-term commitment to the area.

Two key Taskforce initiatives are the establishment of a multi-agency, multi-disciplinary domestic violence child and family team, and a sustained home visiting program for vulnerable families. The Green Valley Domestic Violence team, jointly led by NSW Health and Department of Community Services, aims to improve the health and well-being of children, young people and families, increase interpersonal skills, resilience, self-esteem and safety of adults, children and young people in violent relationship, and ensure better integration of services to improve outcomes for these groups.

The Miller Early Childhood Sustained Home Visiting team is built on the principles and structures of Families First. The intervention consists of over twenty home visits commencing during the antenatal period and continuing for the first two years after birth, conducted by early childhood nurses and a social worker working in partnership with other health and community workers. The aim is to promote social connectedness, provide guidance in areas such as diet, sleeping, settling and breast feeding, practice preventive public health, and foster early attachment.

The international evidence strongly suggests that taking an inter-sectoral approach to organising the delivery of human services can improve health outcomes and reduce health inequalities.[48]

A program conducted in the Netherlands evaluated the effectiveness of 12 interventions in reducing health inequalities, several of which had an inter-sectoral approach designed specifically to reduce the effects of socio-economic disadvantage on health.

Three of the interventions focused on improving the accessibility and quality of health care services using a collaborative approach between health and human service practitioners and consumers. The systematic approach taken by the Netherlands Ministry of Health has contributed to improved knowledge as well as increased confidence among policy makers and practitioners in taking action to reduce health inequalities.[49]

The UK Social Exclusion Policy Action Team found similar results[50] in a study that looked at neighbourhood renewal programs that aimed to close the health gap between Britain's poorest neighbourhoods and the national average. The team's report outlines the importance of involving communities and other community-based organisations in a collaborative way, and provides mechanisms for achieving this involvement.

Shared Vision (Wula Wula Nga)

Wula Wula Nga is based in Lismore and provides a 'one stop shop' for information for Aboriginal people living in the Richmond Valley, including the availability of health services, how to use these services and where to access them. Shared Vision was started in 1995, involving 19 agencies including the NSW Department of Community Services, NSW Department of Health and NSW Police Service. The program was established in response to the difficulties Aboriginal people can experience in understanding the operation of government agencies, the services available to them as well as the best way to access these services, and the need for support for Aboriginal workers. The program is also concerned with promoting linkages and partnerships between Aboriginal communities and government organisations in order to enhance understanding and improve the quality of life for Aboriginal people.

The NSW Government has improved inter-sectoral collaboration and planning at the regional and local levels in several ways. The NSW Premier's Department supports significant interagency collaboration through the Regional Coordination Management Groups and through various interagency programs such as the Community Solutions and Crime Prevention Strategy. The Cabinet Office led the development of Families First involving a comprehensive program for improving child health outcomes. The overall capacity for collaboration between government departments has also been extended and enhanced through initiatives such as the Human Services Chief Executive Officers' Forum.

NSW Schools as Community Centres Program

The Schools as Community Centres Program involves the NSW Department of Health, NSW Department of Community Services, NSW Department of Housing, and NSW Department of Education and Training. The program operates within schools in selected communities to work with families with children under five years. Through these centres, staff are able to encourage and support parenting, actively promote community involvement in providing services for children, and encourage and assist parents to access existing mainstream services in the community.

Through these mechanisms government departments and service providers have been encouraged to work with each other in whole-of-government or cross-agency arrangements, and to work with communities through NGOs and other community bodies. Many of these arrangements are supported by formal agreements including Memoranda of Understanding among government, non-government and community service providers.

Initiatives such as those highlighted in this section confirm:

- The health sector's important advocacy role in advising other government agencies about the impact of their policies and plans on the health of local populations and the ability of these communities to lead healthy lives.

- The value of taking a coordinated approach to service delivery for disadvantaged communities and groups.
- The importance of making better or joint use of existing resources and human service delivery sites.

The NSW Government needs to build on this work in a systematic and sustainable way.

The effectiveness of collaborative initiatives are often diminished due to:

- Limited ongoing support or leadership by a central agency.
- Insufficient education or skills training in collaboration, capacity building and devolution for local and regional managers.
- Tendency to ignore ineffective interventions, or to withdraw funding without adequate evaluation or learning from mistakes.
- Short-term nature of interventions associated with the political cycle.
- Short-term nature of funding and its inflexible allocation between agencies.
- Short-term focus on continual reporting and accountability mechanisms, which work against longer-term change and outcomes.

Overcoming these limitations will require bi-partisan and central agency support and a commitment to innovation, long-term change and learning from previous interventions.

Human services planning on the Central Coast

The Central Coast Regional Management Coordination Group, established by NSW Premier's Department, has endorsed Warnervale-Wadalba as one of four main urban release areas for the Greater Metropolitan Region. Planning for this greenfield site will benefit from a strategic approach to the human services needs of the new community. The Community Support and Human Services Plan for Warnervale-Wadalba identifies desired social outcomes, as well as key issues likely to affect the residents' quality of life, and then sets out the facilities, framework and processes for delivering a comprehensive package of human services required to achieve those outcomes.

It is important to be able to measure and evaluate the impact of inter-sectoral initiatives. Government agencies regularly invest substantial funds in initiatives aimed at improving the health and wellbeing of the general community and particular population groups. Such investments where they occur in isolation can duplicate the work of other agencies.

There is a need to develop skills to review and develop initiatives across the human services sector to ensure funding occurs in a more informed way. In the United Kingdom, cross-sector reviews are proving an effective way of dealing with a broad range of issues and changing patterns of government investment.[51] NSW Health must also explore with other government agencies the potential benefits of an inter-sectoral approach.

The focus of strategies in this area is the development of integrated planning, service delivery and evaluation mechanisms to encourage collaboration. Attention is given to the need for inter-sectoral action to improve the health and wellbeing of Aboriginal people in NSW. This offers the opportunity to build on current experience in this area because Aboriginal health is an area where inter-sectoral action was first undertaken.

Health related transport for patients at Dubbo/Lourdes Hospital Respite Daycare

Macquarie Area Health Service has negotiated a partnership agreement with a local bus operator and the community transport service to meet the transport needs of people attending the Stroke Respite Daycare at Lourdes Hospital, Dubbo. Due to capacity constraints this demand could not be addressed by traditional transport operators. The bus operator provides regular transport utilising staff drivers and down time in the existing fleet maintained for the NSW Department of Education and Training Special Education Transport contracts. The community transport provider manages bookings and data collection. The vehicles are fully funded by the NSW Department of Education, this service can be purchased at less than the comparable cost of the hospital maintaining its own bus and employing a driver directly.

5. Organisational development: building capacity to act

Goals

To increase the NSW health system's capacity to address health inequities through improved systems, infrastructure and workforce development.

Discussion

Embedding equity into the day-to-day work of NSW Health requires a strong organisational approach, which encompasses the following:

- An understanding of the potential impact of actions to improve health status and reduce health inequities.
- Good information on the quality of care provided for all users of health services, and on any differences in the quality of care received by different groups.
- An understanding of the policies and actions that will reduce health inequities effectively, and how these can be disseminated throughout the health system.
- Information on patterns of health inequity across NSW and within Area Health Services.
- A skilled workforce that can work effectively with disadvantaged groups, other government departments and NGOs.
- Adequate resources to invest in long-term planning and interventions.

In *A Framework for Building Capacity to Improve Health*,[52] NSW Health developed a model that recognises the importance of organisational development. This model identifies five domains in which a system, organisation or community needs to build capacity:

- Organisational development
- Workforce development
- Resource allocation
- Leadership
- Partnerships

Figure 6 outlines the key elements of the capacity building framework developed by NSW Health. This organisational approach has the potential to increase the range of people, organisations and communities that can address health problems, especially problems related to inequity and social exclusion.

The NSW health system is made up of many public and private organisations and subsets of organisations.

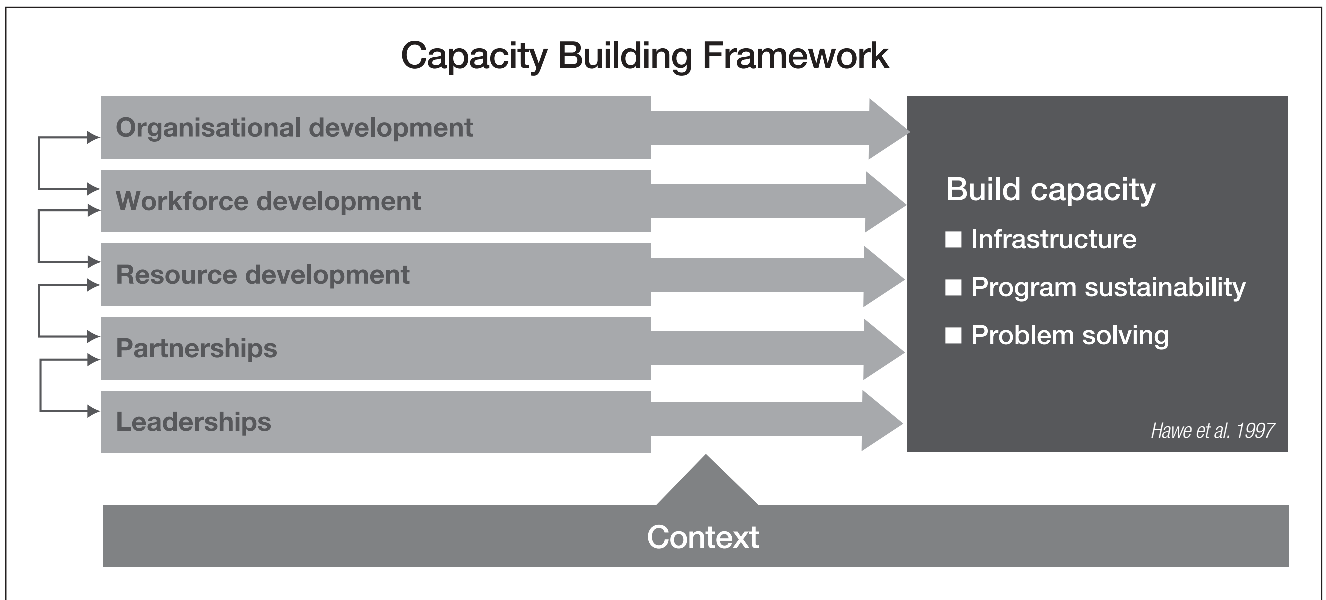
The public health system comprises the NSW Department of Health, Health Services, as well as individual components of the system such as public hospitals, secondary services and primary and community health services. These components may in turn be further broken down into, for example, clinical departments, specialist services in hospitals, and targeted services within community health.

The health system also includes two additional sets of organisations. These are the private health sector, ranging from general practice through to large, private hospitals, and the non-government sector, ranging from Aboriginal community controlled organisations to large not-for-profit agencies to small self-help groups.

Building workforce capacity in Far West NSW

Far West Area Health Service is committed to helping its staff members develop and maintain their skill levels. A comprehensive two year course for Aboriginal Health Workers leading to a Diploma in Primary and Community Health provides theoretical and practical training and has enabled the Area Health Service to maintain and increase a significant Aboriginal Health Worker workforce. Other strategies to address workforce isolation include bringing workshops to the Far West and using communications technology such as videoconferencing and satellite programming for training.

Figure 6. The Capacity Building Framework, NSW Health, 2000[53]



The organisational capacity to assess whether actions and investments are improving health and reducing health inequities must be developed at all levels of the NSW health system, including but not limited to clinicians, project officers, managers and Area Health Service Board members. Over recent years, interest has been growing in the development of methods for assessing the impact of health-related decisions on health outcomes, and their contribution to reducing or widening health inequities.

The NSW health system needs to be able to make prompt assessments of the health impact of new policy initiatives developed by NSW Health or sponsored by The Cabinet Office and other government agencies. Where the health impact of a proposed policy is generally known, a panel of experts could undertake a Rapid Health Impact Appraisal of the positive and negative effects of such policies. In other cases a more comprehensive health impact assessment may be required. It is therefore necessary for NSW Health to develop a range of standardised approaches for assessing and comparing new policy initiatives in terms of their potential in reducing health inequities.

Aboriginal Health Impact Statement

The NSW Health Aboriginal Health Impact Statement aims to ensure NSW Health incorporates the health needs and interests of Aboriginal people in the development of new health policies and programs.*The Aboriginal Health Impact Statement* represents a declaration that appropriate Aboriginal consultation and negotiation processes have taken place, and that Aboriginal needs and interests have been properly considered. Following the sucessful completion of a trial during 2003,*The NSW Health Aboriginal Health Impact Statement* will be fully implemented across NSW Health from June 2004. This will ensure greater focus on improving the health and health care needs of Aboriginal people.

From an equity perspective, there are opportunities at the Health Service level for enhancing organisational development in the following areas:

- The relationship between Health Services and NGOs.
- Collaboration among the human services agencies.
- Better communication between the NSW Department of Health and Health Services.
- Development of the workforce to work across sectors.

- Promoting equity as core business.
- Strengthening research and evaluation capacity.

Participants in the Technical Working Groups and regional workshops conducted in the development of *In All Fairness* suggested the following strategies for developing better capacity in Health Services:

- Building equity into the Quality Framework.[54] There are presently no indicators that adequately reflect access and equity, and it is important to ascertain whether access and quality of care are related to the cultural and/or socio-economic background of people using health services, rather than their level of need.
- Providing opportunities for people to share their experiences, and to access the evidence for policies and practices that have proven effective or shown promise.
- Providing access to long-term funding for health sector and inter-sectoral policies and programs.
- Providing opportunities to work in other government or non-government organisations.

Also, the Department has recently developed a set of high level NSW Health System Performance (Dashboard) Indicators that allow key aspects of health and health services to be examined at Area Health Service level as well as providing a broad Statewide overview. The indicators reflect the goals of NSW Health: Healthier People; Fairer Access; Quality Health Care; and Better Value and are aligned with the Service and Resource Allocation Agreement (SRAA) between NSW Treasury and NSW Health. Relevant indicators are also included in Health Service Performance Agreements.

Healthy People 2005 identifies that a priority area for addressing the social determinants of health is improving the statewide information base on health inequalities and the impact of social factors on health in NSW.[55] *The NSW Chief Health Officer's Report* provides important data on these social determinants, and NSW Health can strengthen its research and evaluation capacity by:

- developing and expanding information systems at the patient and population level, so differences in access and outcomes can be monitored and systematically reported
- developing a set of health-related indicators of disadvantage and inequity
- funding the comprehensive evaluation of interventions designed to address health inequity.

This is consistent with the findings of the literature review in relation to international directions. The report C*anada Health Action: Building on the Legacy*[56] included a recommendation to establish a multi-year transition fund for:

- funding pilot projects that have a sound evaluation and research component, and financing the evaluation components of existing projects
- disseminating the results of these evaluations
- promoting the implementation of the models that prove most effective.

NGOs within the NSW health system generally have a strong community base and incorporate extensive community participation that encourages a strong equity focus. These organisations often provide a more holistic, flexible approach to service delivery and target communities Health Services find difficult to reach, especially Aboriginal people, youth and people from disadvantaged communities. The capacity of the non-government sector to achieve such results would be strengthened through the provision of support for management and training.

Development and promulgation of *In All Fairness* is designed to provide leadership to the health system in pursuing the goal of health equity for the NSW population. At the same time, NSW Health needs to build its capacity to deliver in this area by integrating equity into practice, and establishing a process for measuring the extent to which strategies are taken up by NSW Health.

Equity will not be achieved because this Statement is released or because policies for tackling health inequities are announced. For equity to become entrenched as core business for NSW Health, the strategies adopted must be monitored and skills must be developed and shared across Health Services, partner agencies and the community.

Effective health promotion action to reduce health inequalities

NSW Health funded a project to identify health promotion strategies that are effective in redressing health inequalities. Impetus for the project came from growing awareness among Area Health Service Directors of Health Promotion of the extent of health inequalities in NSW and the lack of evidence-based interventions. In particular, there is concern that many health promotion programs may be exercising greatest influence on health behaviours of the more advantaged members of the community, thereby contributing to widening the health gap between the most and least advantaged in the community. Four Steps Towards Equity: A Tool for Health Promotion Practice, an initiative of the NSW Health Promotion Directors' Network, is an example of how this project will help guide health promotion towards activities that promote more equitable health outcomes. During 2004/05, Phase 2 of this project will use a capacity building approach to disseminate these tools across NSW.

The establishment of a senior level Implementation Review Committee chaired by the Director-General, NSW Health and supported by a broadly based Equity Alliance will help to promote and achieve these aims. The Equity Alliance will work with NSW Department of Health and Health Service staff to:

- assess the degree to which NSW Health currently promotes an equity approach and the extent to which it is implemented in practice
- develop an equity network to enhance Health Services' access to relevant resources
- integrate equity measures in performance accountability frameworks
- evaluate and report on progress in achieving the goals of *In All Fairness*, to ensure that the system has an equity focus and achieves greater equity in health outcomes.

The strategies for this key focus area concentrate on ways to facilitate organisational development and capacity building to integrate the pursuit of equity into practice within the NSW health system.

6. Resources – For long-term improvement in reducing health inequities

Goal

To reorient patterns of investment within the NSW health system to explicitly address health inequities.

Discussion

Achieving equity in health is based on achieving and sustaining the equitable distribution of resources. The resource issue was not originally included as a key focus area for the development of *In All Fairness.* However, it was apparent from the first round of discussions with chief executive officers of health services that resources was seen as an important component of a response to health inequities, and this was confirmed in subsequent consultations and workshops.

NSW Health already gives priority to an equitable allocation of resources through the Resource Distribution Formula (RDF). The RDF recognises that resources need to be allocated on the basis of population numbers and adjusted for factors such as lower socio-economic status, Aboriginality, age and rurality.

There are many ways in which equity can be enhanced through addressing resource allocation and distribution. These include strategies that directly affect and/or are complementary to the RDF. Among the key issues emerging from consultations was the need to improve equity across the health system through long-term investments in infrastructure and programs, and through more targeted approaches.

The distribution and allocation of resources is a national, state, regional and local issue. The separation of funding of health services between the Commonwealth and State and Territory Governments, the complexity of mix between the public and private health care systems and the mix of small and large-scale organisational structures has sometimes led to inefficiency and duplication of effort.

There is now greater awareness of these issues by all levels of government. The coordinated care trials and other recent programs reflect attempts to find new ways of working and new ways of financing health services. The development of a more rational health financing system provides enormous potential for increasing the focus on equity in resource considerations.

There is broad agreement that the RDF has made significant advances in bringing about a more equitable funding system between Health Services. It is also recognised that the RDF is not designed specifically to address past levels of under-investment and may not recognise pockets of disadvantage within Health Services, and there is a willingness to further refine the RDF so resources can be shared more equitably across the State. One subgroup requiring special consideration in relation to equitable resource allocation is the prison population due to the high levels of health need and the special difficulties of service provision in correctional facilities.

Better services for prisoners

Prisoners are a marginalised subset of a population group already marginalised in the community. People often enter prison with pre-existing health problems because they have not accessed health services in the community. The Corrections Health Service's survey of inmates in 2000/2001 provided enhanced information about this group, which enabled the Health Service to gain a better understanding of the demand for health services by prisoners, and improve continuity of care in the community upon their release. Another study being conducted over three years by the National Health and Medical Research Council is measuring comparative mortality in NSW prisons and identified several factors, including ageing, higher proportion of Aboriginal inmates and poorer general health status of the prison population, which contributed to higher mortality rates.

As equity of resource allocation improves between Health Services there is growing interest in also examining the way resources are invested within Areas. Patterns of historical investment may mean resources are not fairly distributed within Health Services. Established patterns of investment in service delivery also need to adapt over time in response to changing population demographics.

Review of community based services in Mid Western Area Health Service

In 1999 Mid Western Area Health Service conducted a Review of Community Based Services, which identified certain inequities in the distribution of community health services. This resulted in a service mapping exercise and the development of a model of service distribution that places greater emphasis on equity. The primary aims of this model are to:

- ensure an equitable distribution of community based services across Mid Western Area Health Service
- promote the efficient use of available resources through service networking
- ensure (where possible) that communities have access to allied health services within 50 kilometres
- provide a strategic framework for the planning and development of community-based services.

A major challenge in resource allocation is achieving a balance in investment between improving the health of the population as a whole and providing high-quality treatment services to sick individuals. The evidence suggests that 'upstream' interventions that attempt to prevent illness, encourage early identification of health problems or address the wider social determinants of health have the most significant impact on the health of people who are most vulnerable.[57]

The changing role of hospitals and the treatment of more acute and chronic medical conditions within the community is increasing the pressure on the primary health care system. There is a perception that funding has not followed the patients into the community sector and this requires further attention and investigation. There is also pressure to invest in the prevention of long-term health problems through community-based early intervention or inter-sectoral programs such as Schools as Community Centres and Families First. For a strong primary health care system, resources need to be allocated to developing both post-acute services and prevention and early intervention services.

A population health model for the provision of mental health care

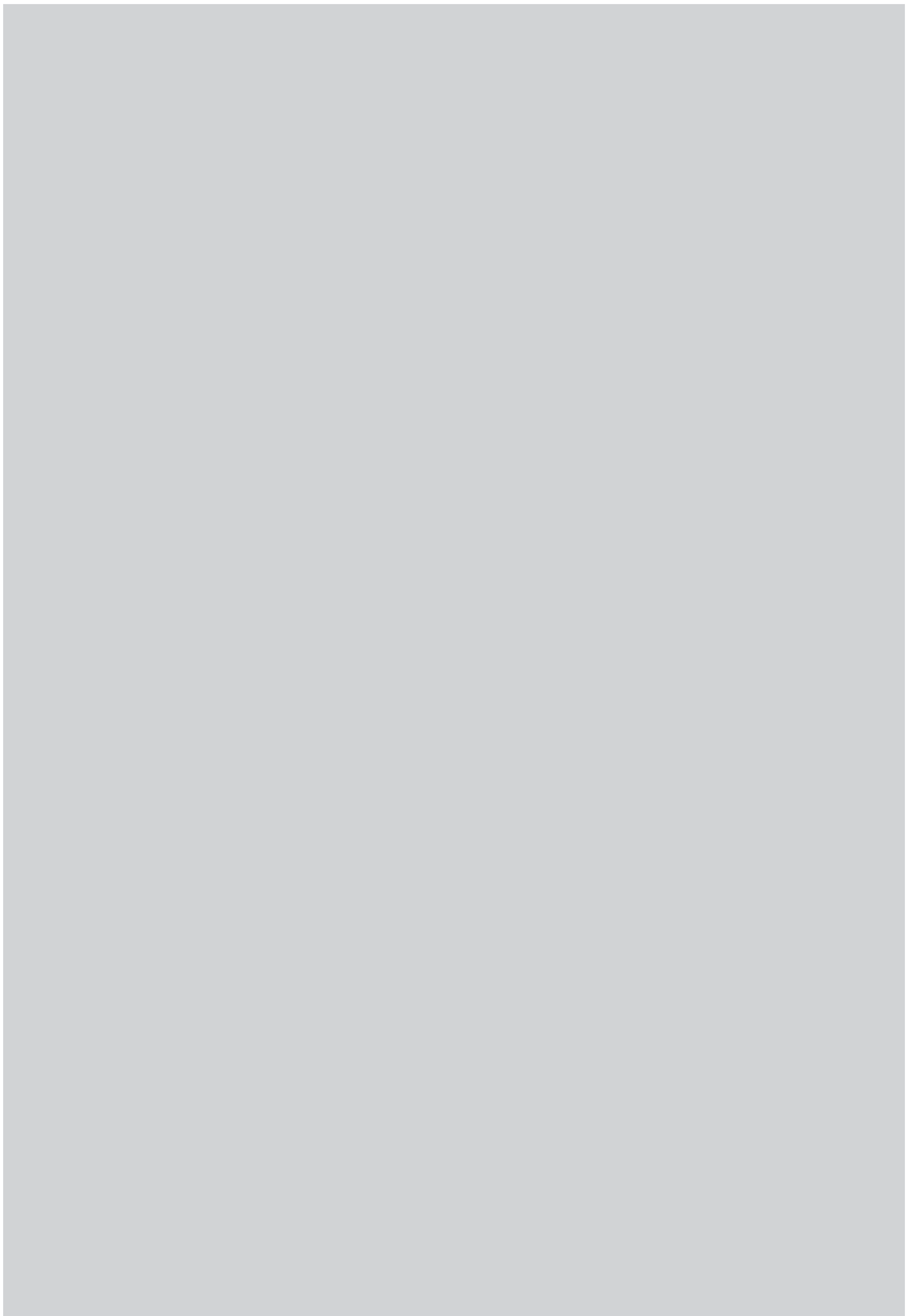
The population health model for the provision of mental health care provides a framework for both population and personal mental health care services in NSW. It utilises the model of the spectrum of interventions from prevention through early intervention to treatment and maintenance, applying these at population and individual levels. It deals with issues across the life span from infancy to old age, and as they apply to special population groups such as peoples of culturally and linguistically diverse backgrounds, and Aboriginal peoples. It conceptualises the provision of care at different levels; namely primary mental health care; secondary or specialist mental health care; tertiary mental health care; and as these apply across the population matrix of different groups.

The framework uses epidemiological indicators and evidence-based practices to identify the population-based need and corresponding mental health interventions as applied in each Area Health Service. It emphasises the importance of outputs, outcomes and evaluation, using this to predict the resources required to provide a standardised 'care package', and further assists Areas with priority settings by providing estimates of the proportions of various health service needs that can be met with current or planned levels of resources.[58]

International evidence shows that health systems focused on primary health care and adequately resourced produce better outcomes. To gain this benefit for NSW would require a major structural change in funding arrangements. The Australian Health Care Agreement offers a mechanism for enhancing resource flexibility to achieve innovative reorientation. To properly incorporate equity in the Agreement, future negotiations must support a reorientation of the health system towards a greater primary health care focus.

The importance of achieving an appropriate balance in resourcing cannot be underestimated. It has always been difficult to sustain interventions that reduce health inequities and promote equity because these are usually long-term strategies that are often unlikely to demonstrate immediate gains and value for investment.

Nevertheless, the evidence shows that a long-term focus on health investment and sustainability is crucial in reducing health inequities and closing the gap between those with the best and poorest health. Accordingly, the strategies for this focus area concern the promotion of equitable resource allocation over realistic timeframes to reduce health inequities.



Strategic directions 4

The strategic directions identify a range of interventions across each key focus area that have been shown to be effective in addressing health inequities.

Implementation of these strategies will be supported by a separate document, *'Integrating Equity into Practice – A Strategies Document for Addressing Health and Equity'*, and the development and refinement of local Equity Profiles as a part of Public Health Plans. The Equity Profiles provide information about areas where Health Services and the NSW Department of Health need to take action to address health and equity. *Integrating Equity into Practice* provides practical examples of successful equity interventions that may be implemented within existing policies, programs and processes.

Reporting on progress against *In All Fairness* could occur through *Healthy People 2005,* at Health Service and statewide levels. Furthermore, achievement of the goals of *In All Fairness* will be reported in the *NSW Chief Health Officer's Report.* Other mechanisms for reporting include the *NSW Health System Performance (Dashboard) Indicators* the *Health Service Performance Agreements* and the *NSW Health Quality Framework.*

Strong beginnings: investing in the early years of life

Goal

To secure good health outcomes for children at birth and throughout their lifespan by concentrating on health care during the antenatal period and the first eight years of life.

Provide proactive antenatal and postnatal care for vulnerable families

1. Further develop systems and programs to identify and support women who may be vulnerable early in pregnancy.
2. Further develop an integrated approach to antenatal and postnatal care for pregnant teenagers and teenage mothers.
3. Develop and incorporate psychosocial assessment as part of a comprehensive assessment delivered to all women in the antenatal and postnatal period to identify families that may be vulnerable and require additional support.

Provide resources for home visiting programs

4. Increase investment in the development and implementation of universal and targeted home visiting services in collaboration with specialist services, other government departments and community organisations.

Adopt a whole-of-government approach to service planning and delivery for children

5. Pilot the use of pooled funding from the human service agencies within one Area Health Service to develop a comprehensive and innovative approach to service planning and delivery for children and their families.

Promote life skills for families with toddlers (0-3 years)

6. Research, develop and implement models and programs to help families with toddlers (0-3 years) develop positive relationships within the family and in the community.

Support the home-to-school transition

7. Develop and implement programs for pre-school aged children and their parents that focus on preparing for the transition to school, so children in the most disadvantaged communities have the same opportunities for learning as those in the least disadvantaged communities.
8. Further develop existing programs aimed at improving parenting practices and reducing behavioural and emotional problems, particularly in pre-school aged children.

Strengthen oral health services for children 0-5 years

9. Develop and resource a preventive oral health program for families from disadvantaged backgrounds and communities with children aged 0-5 years.

Improve access by vulnerable families to nutritious, affordable and high-quality food

10. Resource the development of individual and community nutrition programs for women and children from disadvantaged backgrounds to improve the access of potentially vulnerable families to nutritious, affordable and high quality food.

Greater participation: engaging communities for better health

Goal

To invest in and strengthen community participation in the NSW health system in recognition of the value of individual and community involvement in managing health problems and developing health services.

Increase community involvement by disadvantaged communities and populations

11. Initiatives to increase and improve consumer and community participation within the NSW health system should be enhanced by:
    - promoting equitable participation in planning, service delivery and evaluation across the primary health and acute care sectors
    - promoting the capacity for marginalised groups to participate
    - providing adequate resources for equitable participation.

Increase consumer involvement

12. Identify opportunities for increasing consumer and carer involvement in current and future health service initiatives in order to ensure the participation of relevant target groups and their carers, and maintain focus on the need to reduce the gap in health outcomes between the most advantaged and the least advantaged groups and communities.

Strengthen the role of NGOs

13. Utilise the expertise gained by NGOs in working with disadvantaged groups and communities to identify health issues of particular importance to these groups, to increase the capacity for these issues to be addressed within the wider health agenda, and to engage relevant groups in developing and implementing health policies and programs.

Support community involvement at the Health Service level

14. Resource Community Participation Coordinators in Health Services to develop a range of participation mechanisms, and for providing an annual report on community participation.

Build an evidence base for community involvement

15. Document and evaluate a range of innovative models of effective participation by disadvantaged communities in their local health services.

Developing a stronger primary health care system

Goal

To improve the accessibility and effectiveness of the primary health care system, particularly for those people with the greatest health needs.

Invest in a strong primary health care system

16. Establish a data collection system that clearly identifies and monitors primary health care expenditure within the NSW Health system.
17. Each Area Health Service to define and apply a model of care for primary health care, which specifies the core range and level of services that can reasonably be expected in their communities.
18. Each Area Health Service to implement strategies as identified under Strengthening Health Care in the Community including:
    - undertaking strategic planning for primary health care services
    - defining and applying a model of care for primary health care
    - working towards an optimum mix of investment in health care
    - developing Primary Health Care Networks to deliver integrated primary health care services to local communities.
19. Work with Aboriginal community controlled and other non-government organisations to deliver primary health care services to hard-to-reach communities and groups, either by devolving services to these organisations or by working in partnership with them.

Provide leadership

20. Each Health Service to have a Primary Health Care Director at senior management level responsible for developing a comprehensive primary health care system.

Note: Also see strategies 46 and 47 under strategic directions for key focus area 6, Resources for long-term improvement in health and equity.

Regional planning and inter-sectoral action: working better together

Goal

To increase the capacity of the NSW health system to work with other sectors to address health inequities through improved regional planning and inter-sectoral action.

Evaluate the impact of government policy and programs on health

21. NSW Health in collaboration with the Human Services Chief Executive Officers' Forum, NSW Treasury and relevant Commonwealth Departments, fund a review that explores the impact of other agencies' programs on the health of the people of NSW, and the impact of NSW Health programs on the core aims of other relevant government agencies. Initially the review should focus on the adequacy of current patterns of government investment in developing young adults who are able to participate fully in society.

Work inter-sectorally on Aboriginal health

22. Identify and act on key inter-sectoral equity targets in collaboration with the Aboriginal Health and Medical Research Council, the Commonwealth (through the Aboriginal Health Forum), the Aboriginal and Torres Strait Islander Commission and other relevant agencies, to improve Aboriginal health outcomes.

Share physical assets

23. Negotiate with other human service agencies, the NSW Department of Commerce, NSW Treasury and NSW Premier's Department for six pilot sites chosen in both metropolitan and rural/remote centres, to develop integrated sites for school, primary health care, and community services.
24. Negotiate with other government and community agencies to ensure capital and service partnerships are included in any future Multi-Purpose Services developed as part of the Strengthening Health in Rural Smaller Towns program.

Support regional planning

25. Promote establishment of integrated human services planning units in six disadvantaged regions to assist agencies in addressing the range of factors that affect health outcomes.

Fund more local integrated planning and service delivery

26. Work with other government and non-government organisations and community groups to develop a coordinated approach to service delivery for disadvantaged communities and groups.

27. Health Services to allocate a proportion of their budgets to integrated planning and service delivery within disadvantaged communities, and to report on this investment from Performance Agreement negotiations commencing in 2004/05.

Organisational development: building capacity to act

Goal

To increase the NSW health system's capacity to address health inequities through improved systems, infrastructure and workforce development.

Develop organisational capacity within NSW Health to evaluate health impact

28. Develop a process for undertaking Rapid Health Impact Appraisals within NSW Health to identify the health impact of existing and new policies.

29. Fund the development of pilot approaches to health impact assessments in order to develop standardised tools for undertaking comprehensive health impact assessments of NSW Health initiatives.

Develop the capacity to address health inequities through quality health services

30. Include in NSW Health Quality Framework an equity domain focussing on access to health services, quality of care and health outcomes between different groups in the population.

Facilitate organisational development to integrate equity into practice

31. Establish an Equity Alliance to work within the NSW Department of Health and with Health Services in addressing health inequities.

32. Establish and support an Implementation Review Committee that is chaired by the Director-General, NSW Health, to monitor implementation of strategies outlined in this Statement across NSW Health.

Strengthen capacity for research and evaluation

33. Develop and expand information systems at patient and population levels to ensure that differences in access and differences in outcomes are routinely reported for equity.

34. Develop in collaboration with other human service agencies a health-related indicator of disadvantage to identify priority areas for intervention through community based strategies, with the aim of ensuring resource decisions effectively account for the needs of disadvantaged groups and communities.

35. Fund and support comprehensive evaluation of the health impact of universal and targeted programs, policies and interventions designed to address health inequity to improve the knowledge and evidence base of work in this area.

Develop workforce skills and capacity to address health inequities

36. Undertake a workforce needs assessment for people who work with disadvantaged communities, to ensure they have the capacity on a day-to-day basis to address the integration of equity as a core focus within their work.

Develop the capacity of NGOs

37. Support establishment of a management training unit that will purchase and provide training and skills development to workers within the non-government sector and community based organisations (including resident groups), to equip these organisations to deliver high-quality services and programs, especially to the most disadvantaged groups in the community.

Develop workforce capacity across sectors

38. Increase opportunities for joint appointments between agencies and the movement of key staff across government and non-government organisations and the private sector, to improve knowledge of the operating constraints within each sector and expose staff to new approaches and different organisational environments.

Provide leadership in redressing health inequities

39. Encourage and recognise leadership and better practice in redressing health inequities, through the development of awards for services and initiatives that demonstrate better practice.

Resources for long-term improvement in reducing health inequities

Goal

To reorient patterns of investment within the NSW health system to explicitly address health inequities.

Refine the Resource Distribution Formula

40. Maintain and refine the RDF to include a greater focus on reducing health inequities.

Match resources with need

41. Develop a health strategy for people living in remote areas that recognises their unique situation and provides them with adequate resources.

42. Develop a strategy that recognises the unique and difficult circumstances in which health services are provided to prisoners, and ensure that resourcing of Corrections Health Service reflects the unique health needs of its population.

Promote equitable resource allocation within Health Services

43. Establish a system for monitoring the quality of care and health outcomes across the population, to inform service development and resource allocation.

44. Develop internal resource distribution strategies to guide resource allocation in each Health Service, with a clear focus on reducing health inequities.

Target growth and enhancement funding to reduce inequity

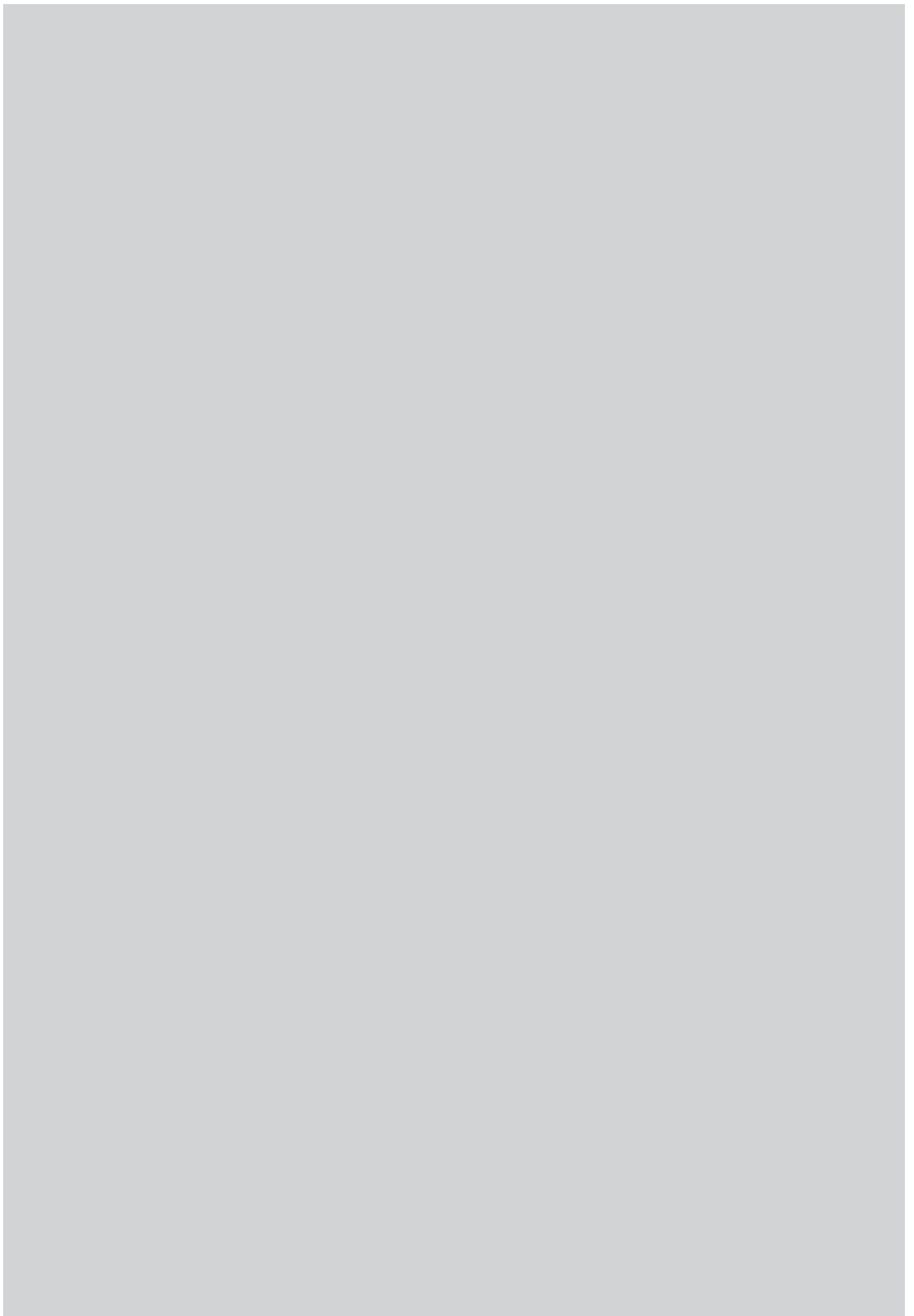
45. Target future growth and enhancement funds on improving the health of all groups in the population and to reducing health inequities.

Incorporate equity in the Australian Health Care Agreement

46. Negotiate for the next Australian Health Care Agreement to support an orientation of the health system towards a greater focus on primary health care.

Implement a strong primary health care system with an equity focus

47. Ensure future investment in a stronger, more effective, primary health care system has greater focus on health promotion, early intervention and support in the community, and not only on post-acute services in the community.



Appendix A – Key stakeholders

Key stakeholders involved in the development of *In All Fairness*

Project Management Committee	
Mr Michael Reid	Director-General, NSW Department of Health
Dr Andrew Wilson	Chief Health Officer, Deputy Director-General, Public Health, NSW Department of Health
Associate Professor Debora Picone	Deputy Director-General, Policy, NSW Department of Health
Professor John McCallum	Dean, Social and Health Sciences, University of Western Sydney
Mrs Elizabeth Harris	Director, Centre for Health Equity Training, Research and Evaluation
Associate Professor Peter Sainsbury	Director, Division of Population Health, Central Sydney AHS
Dr Jim Hyde	Director, Health and Equity Project
Ms Alix Goodwin (until June 2001)	Acting Director, Health Service Policy Branch, NSW Department of Health
Ms Melissa Gibson (from June 2001)	Acting Director, Primary Health and Community Care Branch, NSW Department of Health
Mr Bill Bellew	Director, Health Promotion Branch, NSW Department of Health

Health and Equity Project Team	
Professor John McCallum	Dean, Social and Health Sciences, University of Western Sydney
Mrs Elizabeth Harris	Director, Centre for Health Equity Training, Research and Evaluation
Associate Professor Peter Sainsbury	Director, Division of Population Health, Central Sydney Area Health Service
Dr Jim Hyde	Director, Health and Equity Project
Ms Sarah Simpson	Project Officer, Health and Equity Project Team

Reference groups

Project Reference Group	
Professor John McCallum (Chair)	Dean, Social and Health Sciences, University of Western Sydney
Dr Tony Sherbon	Chief Executive Officer, Illawarra Area Health Service
Associate Professor Peter Sainsbury	Director, Division of Population Health, Central Sydney AHS
Dr Richard Matthews	Chief Executive Officer, Corrections Health Service
Mr Jeff Nelson	Senior Project Officer, NSW Department of Community Services
Ms Elizabeth Kuzmanovska	Senior Policy Officer, Health (Locum), NSW Council of Social Services
Ms Margaret Hansford	Chief Executive Officer, FPA Health
Ms Sandra Bailey	Chief Executive Officer, Aboriginal Health and Medical Research Council
Mr Craig Patterson (until May 2001) Ms Victoria Toulkidis	Director, Health Policy Unit, Royal Australasian College of Physicians
Dr Jane Hall	Director, Centre for Health Economics Research and Evaluation
Ms Margaret Scott (for Professor Steven Boyages)	Program Manager, Aboriginal Vascular Health Program, Centre for Research and Clinical Policy, NSW Department of Health
Ms Anne Connolly (for Ms Alix Goodwin and then Ms Melissa Gibson)	Primary Health and Community Care Branch, NSW Department of Health
Ms Carol Madge	Director, Population Health, Southern Area Health Service
Ms Debbie Dagg	Policy Manager, Strategic Projects Division, NSW Premier's Department
Mr Nick Mersiades	NSW State Manager, Commonwealth Department of Health and Aged Care
Professor Graham Vimpani	Professor of Paediatrics and Child Health, University of Newcastle, Director of Child Adolescent and Family Health Service
Ms Elena Misheva	Director, Alzheimer's Association of NSW
Ms Yvonne Shipp	NSW Health Consumer Advisory Group
Ms Chris Currey	Director, Equity Programs, NSW Department of Education and Training
Ms Elizabeth Harris	Director, Centre for Health Equity Training, Research and Evaluation
Dr Jim Hyde	Director, Health and Equity Project

NSW Department of Health Reference Group	
Ms Alix Goodwin (Co-Chair until June 2001)	Acting Director, Health Services Policy Branch
Ms Melissa Gibson	Acting Director, Primary Health and Community Care Branch
Dr Jim Hyde (Co-Chair)	Director, NSW Health and Equity Project
Mr Bill Bellew	Director, Health Promotion Branch
Ms Louise McMeeking	Senior Policy Adviser, Community Relations, Health Public Affairs
Ms Fefe Lawson	Private Health Care Branch
Ms Catherine Katz	Director, Government Relations
Ms Carmen Parter (for Mr Tim Agius)	Manager, Aboriginal Health Branch
Dr Alan Patterson and Ms Jennifer Sheehan	Director, Oral Health Branch
Ms Kym Scanlon	Policy Manager, Centre for Mental Health
Mr E Sondalini	Structural Funding and Policy
Mr Michael Stokes	Director, Capital and Asset Management Branch
Ms Sarah Simpson	Project Officer, NSW Health and Equity Project

Technical Working Groups for key focus areas

1. Strong Beginnings	
Professor Graham Vimpani (Chair)	Professor of Paediatrics and Child Health, University of Newcastle
Dr Elisabeth Murphy	Director, Child Health, NSW Department of Health
Dr Lesley Laing	Director, National Domestic and Family Violence Clearinghouse
Ms Maree Walk	Director, Centre for Children, NSW Benevolent Society
Mr Jeff Nelson	Senior Project Officer, NSW Department of Community Services
Professor David Henderson-Smart	Perinatal Unit, University of Sydney
Mr Michael Kakakios	Policy Manager, Health Services Policy, NSW Department of Health

2. Greater Participation	
Ms Margaret Hansford (Chair)	Chief Executive Officer, FPA Health
Ms Judy Finch	Program Officer, South Western Sydney Area Health Service
Dr Garth Alperstein	Area Community Paediatrician, Central Sydney Area Health Service
Ms Deirdre Degeling	Director, Health Development, National Heart Foundation
Ms Bronwyn Wilkinson	Manager, Community and Extended Care Services, Northern Sydney Area Health Service
Ms Louise McMeeking	Senior Policy Adviser, Community Relations, Health Public Affairs, NSW Department of Health
Ms Janet Meagher	NSW Mental Health Consumer Advisory Group
Dr Jim Hyde	Director, NSW Health and Equity Project

3. Strong Primary Health Care System (formerly A Focus on Place)	
Ms Cathy Noble	Senior Project Manager Place, South Western Sydney
Professor Mark Harris	Professor of General Practice and Head of School of Community Medicine, University of NSW
Mr Bernie Coates	NSW Department of Housing
Associate Professor John Beard	Director, Southern Cross Institute for Health
Mr John Nicolades	Director, Affordable Housing Service, NSW Department of Urban Affairs and Planning
Dr Siun Gallagher	Director, Service Development and Population Health, Western Sydney Area Health Service
Ms Sarah Simpson	Project Officer, NSW Health and Equity Project

4. Regional Planning and Inter-sectoral Action	
Dr Tony Sherbon (Chair)	Chief Executive Officer, Illawarra Area Health Service
Dr George Bearham	Executive Director, Prince of Wales Hospital
Dr Diana Horvath	Chief Executive Officer, Central Sydney Area Health Service
Dr Andrew Penman	Chief Executive Officer, NSW Cancer Council
Mr Michael Hogan	Director, Strategic Projects Division, NSW Premier's Department
Ms Alix Goodwin	Acting Director, Health Services Policy Branch, NSW Department of Health
Ms Chris Currey	Director, Equity Programs, NSW Department of Education and Training
Dr Jim Hyde	Director, NSW Health and Equity Project

5. Organisational Development	
Ms Carol Madge (Co-Chair)	Director, Population Health, Southern Area Health Service
Ms Ros Bragg (Co-Chair till March 2001)	Health Policy Officer, NSW Council of Social Services
Dr Raad Richards	General Manager, Liverpool Health Service
Ms Michele Noort	Executive Director, Service Development and Population Health, Wentworth Area Health Service
Ms Shelley Bowen	Manager, Health Promotion Strategies & Settings Unit, NSW Department of Health
Dr Jim Hyde (Co-Chair from March 2001 for Ros Bragg)	Director, NSW Health and Equity Project

Appendix B – How *In All Fairness* was developed

A Project Management Committee and two Reference Groups were established to provide management and input to *In All Fairness*. Members included senior executives and representatives from the NSW Department of Health, Health Services, other NSW government agencies and NGOs.

Five Technical Working Groups were established from the membership of these groups and other nominations. The Technical Working Groups were responsible for developing specific input on one of the five key focus areas for inclusion in the Statement.

A Targeted Literature Review was commissioned to help identify the range of health and equity interventions available and the evidence about the outcomes from these interventions.

During March-May 2001, six Health and Equity Workshops were held with senior executives from NSW Department of Health, other human service agency executives, Health Services, and representatives from peak NGOs. The outcomes from these workshops were incorporated into *In All Fairness*.

Interviews with the chief executive officers of health services were held both at the beginning of the project and once preliminary strategies had been developed.

The Targeted Literature Review and the NSW Health and Equity Workshops Report are important companion documents to *In All Fairness*.

The representative nature of the Reference and Technical Working Groups and the Health and Equity Workshops provided a mechanism for verifying current findings in the literature about the effectiveness of interventions, as well as identifying interventions (particularly in the other key focus areas) that were effective and either not represented in the literature reviewed, or not documented anywhere in the literature.

The Targeted Literature Review and the action research process of the Workshops and Reference groups formed the basis for identifying and selecting strategies.

Appendix C – Definitions

Capacity building

A process of building on existing skills, structures, partnerships and resources to increase the range of people, organisations and communities that can address health problems in a sustainable way.

Disadvantage

Disadvantage is a pattern of limited life opportunities in health or in social or economic wellbeing. Socio-economic disadvantage is known to limit life opportunities, particularly through poorer health.

Health

In this document 'health' encompasses physical, mental and emotional health and wellbeing. There is a similarly broad definition in *Ensuring Progress in Aboriginal Health:*

> *Health does not just mean physical well-being ofthe individual but refers to the social, emotional, and cultural well-being of the community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life. Health care services should strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of their communities.*[59]

Health inequities and health inequalities

The terms 'health inequities' and 'health inequalities' are often used interchangeably but there is a conceptual difference between them. The term 'health inequality' describes differences in health status usually between groups, such as the differences in health between older and younger people that occur due to natural factors. The term 'health inequities' encompasses the notion some differences are unfair and avoidable, such as the poorer health of Aboriginal people in NSW.

Health outcome

A change in the health status of an individual or group of people or a population that is wholly or partly attributable to a health intervention or a series of interventions

Targeted services

Targeted services tackle the health needs of particular individuals and communities:

- where existing basic services may not cope with the level of illness and need experienced (as in some Aboriginal and Torres Strait Islander communities)
- where basic universal services do not cover specific health needs resulting from chronic illness or disability (such as the developmental needs of children with disabilities, or people with mental illness)
- where different approaches are required because of adverse health outcomes resulting from factors such as discrimination (eg reduced access to kidney transplantation for Indigenous Australians because of best-practice guidelines about tissue matching)
- where different approaches are required because specific cultural factors and conditions make mainstream basic services inappropriate (such as Aboriginal health and refugee health services).

Universal services

Universal services are available to all people and all communities. They include:

- basic primary health services (including access to GPs), health promotion and prevention services (including sun protection, drug and alcohol and Quit smoking programs), and early childhood home visiting services
- public hospital services (including cancer treatment services, renal dialysis and cardio-vascular services).

Vulnerability

Vulnerability is the increased susceptibility to adverse health events that may be experienced through chronic health problems (such as mental illness or diabetes), during life transitions (such as adolescence and widowhood) or due to adverse social, economic or physical environments (such as discrimination or poverty).

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Notes

SHPN (PHCP) 040097