

LINKING PUBLIC HEALTH AND PERSONAL HEALTH

GUEST EDITORIAL

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When considering health inequalities, it is essential to consider the social causes, context, and consequences of the inequalities (that is, the big picture) as well as the meanings and manifestations of the inequalities in the lives of individuals (that is, the fine grain). Or, to adopt Charles Wright Mills's terminology in *The Sociological Imagination*, it is essential to be able to distinguish (and to understand) the ineluctable links between 'the public issues of social structure' and 'the personal troubles of milieu'.¹ This, the fifth, and for the time being the final, issue of the *NSW Public Health Bulletin* to focus on health inequalities, illustrates the links between public health issues and personal health troubles.

Seven articles are presented on the health of, and health care services for, particularly disadvantaged groups of Australians: Aborigines, people with particular illnesses (renal and vascular disease, mental illness, and physical disability), refugees, and obese people. Although the approaches adopted by the authors vary greatly, some recurrent themes emerge:

- having a broad, biopsychosocial (rather than limited, biomedical) understanding of the causes of a problem is more likely to lead to the development of appropriate preventive and treatment services;
- health problems tend to accumulate in the same individuals and the same communities, rather than being randomly distributed throughout society;
- when disadvantages are accumulating, interventions that break the vicious cycle of disadvantage are needed;
- difficult problems often require innovative interventions, which if successful need to be implemented, with modifications as necessary, wherever the problem exists;
- the availability and distribution of health care services does not always match the need for those services;

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- the patient's ideas about their own 'most important' problems and needs may be very different from the health professional's diagnosis and recommended treatment;
- the health care system often fails to provide quite simple services and facilities that would benefit disadvantaged people;
- notwithstanding the very best intentions of health services providers, disadvantaged people often face a variety of physical, cultural, financial, and attitudinal barriers to accessing health services;
- professional expertise and modern technology are essential elements of patient care, but so are listening, empathy, humanity, and flexibility—particularly when dealing with patients with vastly different life stories;
- particularly when dealing with disadvantaged and minority groups, community consultation, and involvement are essential elements in the success of an intervention.

In addition, Mahoney provides an overview of an emerging technology, Health Impact Assessment. Whether it be human health or the environment, whether it be local or global, it is easy to think of many policies, programs, and developments that have had unexpected and often deleterious consequences. Health Impact Assessment is developing out of Environmental Impact Assessment, in an attempt to predict and optimise the consequences for health of developments inside and outside the health portfolio. Interestingly, NSW has started to go down this track. Under the Gaming Machines Regulation 2002, a Social Impact Assessment (SIA) of the likely impact on the local community must be conducted whenever an application is made to increase the number of poker machines in a hotel or club. It is a requirement that the SIA be sent to the relevant area health service for comment before the Liquor Administration Board makes a decision on the application.²

To conclude our responsibilities as guest editors of this series of the *NSW Public Health Bulletin* focusing on inequalities in health, we would like to emphasise that:

- there are substantial and persisting inequalities in health in NSW: simply, the more affluent and/or privileged a person or group is, the healthier they are;
- the inequalities are similar in origin and magnitude to those observed in the rest of Australia and other developed nations;
- many of these inequalities are inequitable; that is, they are both preventable and unjust;
- health inequalities have their origins in upstream factors (social, economic, and environmental), midstream factors (psychosocial and behavioural) and downstream factors (genetic and physiological) that operate globally, nationally, locally, and individually;
- routine data collections must be maintained to monitor changes in inequalities in Australia;
- regular reporting of an index of human and social capital would help to reorient thinking on social and

economic progress from a 'wealth-producing economy' to a 'health-producing society';³

- the emphasis of research should move away from simply describing health inequalities towards understanding their origins and developing and evaluating interventions to reduce them;
- lay knowledge and more sophisticated quantitative research methods must be used to understand the complexity of factors that create and maintain health inequalities;
- an evidence base of effective interventions must be developed;
- while social and political change is required at the global and national levels to reduce health inequalities, there is also much—that is often quite simple—that the health system, individual health care workers, and professional organisations, can do to reduce inequalities;
- action is required in many sectors and at many levels, and the health system must become skilled at developing coalitions and working in partnerships;
- all elements of the health system must adopt equity as an explicit goal and develop mechanisms for monitoring its achievement;
- the health system must work *with* disadvantaged individuals and communities (particularly with socially-excluded groups) to alter locally- and personally-modifiable factors that directly affect people's lives. This takes flexibility, sensitivity to cultural differences, long term commitment, and resourcing;
- care must be taken to ensure that health care services—particularly primary and secondary preventive services—do not improve population health while simultaneously exacerbating health inequalities;
- both universal (whole population) programs and programs targeting particular disadvantaged populations are needed to reduce inequalities;
- there is good evidence that investment in the early years of life has a positive effect on current and future health. This offers much scope for reducing health inequalities throughout life;
- health (inequality) impact statements are a promising initiative that warrant further development and testing;
- the increasing interest in equity in health has spawned some promising developments nationally (for instance, Medicare and the Health Inequalities Research Collaboration) and in NSW (for instance, the Resource Distribution Formula, the *Families First* initiative, and the Health and Equity Statement);
- notwithstanding the crucial role of other sectors, health workers must continue to be passionate and informed advocates for comprehensive action to reduce health inequalities;
- success must be judged not only by improvements in the health of the most disadvantaged but also by reductions in the health gap between rich and poor.

In closing, we quote Peter Townsend, one of the authors of the Black Report:⁴ 'While representations of inequality [in relation to, for example, education, race, gender, housing, occupation, earnings, disposable income] are important in themselves and can produce findings of value, they are very restrictive unless they are treated as differences due to, or reinforcing, or influential in shaping, an hierarchical society. We must not pretend they are elements which can be treated, in their relationships with health, as independent of the entire structure. Even more important, the entire social structure has to be invoked to contribute to the full explanation of health in relation to any single one of these elements. In looking for successful programmes to reduce inequalities in health this is the critical first step in devising strategy.'⁵

OBITUARY

It is with considerable regret that the *NSW Public Health Bulletin* notes the death of Sir Douglas Black on 13 September 2002 at the age of 89. During an illustrious career Sir Douglas's appointments included Professor of Medicine at the University of Manchester, first Chief Scientist at the United Kingdom Department of Health,

and President of the Royal College of Physicians. He will, however, be most widely remembered as the chairman of the committee that was commissioned by the UK government to enquire into health inequalities in the UK and published in 1980 what has been known ever since as 'The Black Report'. His obituary in the *BMJ* can be read at: <http://bmj.com/cgi/content/full/325/7365/661>.

REFERENCES

1. Wright Mills C. *The Sociological Imagination*. New York: Oxford University Press, 1959.
2. NSW Department of Gaming and Racing Information Sheet 6/02 (April 2002) available at www.dgr.nsw.gov.au/images/publications/Liquor%20&%20Gaming/Numbered%20-Information%20Sheets/6_02.pdf (accessed 1st August 2002).
3. Eckersley R. Health, wellbeing, and progress. *NSW Public Health Bull* 2002; 13(6).
4. Townsend P, Davidson N, Whitehead M. *Inequalities in Health. The Black Report and The Health Divide*. London: Penguin Books, 1988.
5. Townsend P. *Inequalities in health: The need to construct more comprehensive health policies*. London: Health Education Authority, 1998. ☒

THE RELATIONSHIP BETWEEN THE INCIDENCE OF END-STAGE RENAL DISEASE AND MARKERS OF SOCIOECONOMIC DISADVANTAGE

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The relationship between socioeconomic disadvantage and the health of Australians has frequently been reported,¹⁻³ but there has been no research on the relationship between socioeconomic disadvantage and end-stage renal disease (ESRD). Research on patterns of incidence of ESRD has generally been limited to a description of differences according to age, sex, 'race', and state or territory. In this article we describe the relationship between the incidence of ESRD and indicators of socioeconomic disadvantage at the area level.

METHODS

We report two separate but related studies:

- ESRD incidence among indigenous Australians by Aboriginal and Torres Strait Islander Commission (ATSIC) region;⁴
- ESRD incidence in the total population by Statistical Sub-Division (SSD) within capital cities.⁵

We obtained approval for the studies from the joint institutional ethics committee of the Royal Darwin Hospital and the Menzies School of Health Research.

Databases

Both studies used data from the Australia and New Zealand Dialysis and Transplant Registry (ANZDATA), which maintains a database of patients treated in Australia by maintenance dialysis or renal transplantation.⁶ The registry, funded by commonwealth and state governments and the Australian Kidney Foundation, enjoys the participation of all renal units that provide ESRD treatment. Individual data on levels of income, education, and employment are not collected by ANZDATA. We therefore used regional level socioeconomic data from the 1996 census and the National Perinatal Statistics Unit to examine the relationship between ESRD and disadvantage.

Statistical analyses

In both studies, we allocated patients to geographical regions and calculated an age- and sex- standardised incidence for ESRD. The methods used to allocate patients to regions have been discussed in detail elsewhere.^{5,7} We performed appropriate tests of correlation to determine the association between the standardised incidence ratios for ESRD and markers of regional disadvantage. In both studies, we used Australian Bureau of Statistics (ABS) population figures, derived using 1996 Census information on place of usual residence, to