

## From tearful toddler to strident youth: Tackling health inequalities through primary care

Australia, over many decades, has experienced marked differences in health status between population groups as defined by gender, geography, ethnicity and socio-economic status. For example, affluent, privileged people have better health and lower mortality than poor, disadvantaged people. Australia's health is now one of the best in the world—but the only way for it to improve further is to tackle health inequalities as a central plank of health research, health policy, and health service delivery.

Health inequalities have been found in all developed countries for almost all diseases. For example, the United Kingdom has been tracking the health gap between the rich and the poor for many decades, commencing formally in 1977 with a review chaired by Sir Douglas Black, known as the “Black Report”. Twenty years later the Blair Government reviewed progress through another expert committee chaired by Sir Donald Acheson. They found that health inequalities had either stayed the same or had widened. The three areas recommended by the Acheson Committee as crucial were that: all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities; a high priority should be given to the health of families with children; and further steps should be taken to reduce inequalities and improve living standards of poor households.

Conscious of increasing interest in this issue worldwide, the then Federal Minister for Health, Dr Michael Wooldridge, established in 1999 the Health Inequalities Research Collaboration (HIRC).<sup>1</sup> Its goal was to enhance Australia's knowledge on the causes of and effective responses to health inequalities, and to promote vigorously the application of this evidence to reduce health inequalities in Australia. HIRC's work was organised primarily through:

- A Board, consisting of seven members with expertise in health services and research, whose role was to provide advice to the Minister and the Department of Health and Ageing (DoHA) about linking health inequalities research to health policy. Supported by a small Secretariat within the Population Health Division of DoHA,

the Board was later reconvened as a Ministerial Advisory Committee (MAC).

- Three “virtual” research Networks focusing on Children Youth and Families, Primary Health Care, and Sustainable Communities. Their purpose was to develop research partnerships which would facilitate the sharing of research and coordinate and disseminate evidence (especially on effective interventions), and to consider issues for rural and Indigenous Australians.

The Board and the Secretariat's activities have included organising a national conference on the Social Origins of Health and Wellbeing; sponsoring visits and meeting with overseas experts; establishing and supporting the three Networks, raising issues of health inequalities within the National Health and Medical Research Council, and progressing policy synthesis exercises. Each Network established its own steering committee, developed and maintained a membership base, established websites, produced research papers and conducted workshops.

One of the highlights of HIRC has been the Primary Health Care Network (coordinated by Liz Harris and John Furler), which has a membership of 200 people. It has focused its work around five priority areas: Indigenous health, oral health, rural health, access to PHC services; and the role of PHC interventions in reducing health inequalities.<sup>2</sup> In 2003 a valuable discussion paper, *Research priorities and capacity building issues*, was disseminated. This identified PHC research priorities, placed them within the context of research funding and support, and proposed actions to increase research capacity.

This work was followed by a research project entitled *Action on health inequalities through chronic disease self-management and early intervention. What works? What's the evidence?* This has resulted in the assessment of evidence-based self-management and early intervention strategies to improve the health of disadvantaged communities and reduce health disparities, with special emphasis on diabetes, arthritis and asthma.

Since its inception, HIRC has experienced a number of adjustments that have affected its operation, including change from the Board to the MAC, changes in the location, personnel and functions of the Secretariat, and changes in the Department's requirements of the Networks. There were also significant shifts in the environment within which HIRC operated, including three different ministers and personnel changes at senior levels of DoHA. In addition there was no defined budget, and the limited financial resources available to it have declined over time.

Inevitably these dynamics have affected the reach and impact of the initiative. Nevertheless there is a widespread view amongst key stakeholders that the Networks—particularly the Primary Health Care one—have been successful in their primary task of facilitating the sharing of research, and the coordination and dissemination of research evidence. They have been effective in raising awareness of the issue of health inequalities and keeping it on the policy agenda. Given the modest investments, they have provided a good return. It is vital therefore that the momentum which has occurred to date is maintained and strengthened.

The NHMRC is the most logical source of funding for increased research into health inequalities. It has the existing infrastructure to manage grants, crosses many disciplines, and encourages quality and sustained performance. Consideration should now be given to targeted expenditure which complements the research funding directed at Aboriginal and Torres Strait Islander health issues. But strengthening the research arm is only one strategy. In addition there needs to be a stronger leadership focus within all governments of Australia, at federal, state and territory levels. Health services also need to make a much more profound contribution.

A crucial role for governments is to facilitate the transfer of research findings into policy to reduce health inequalities. This requires a more strategic

capacity than currently exists. Encouragingly, all jurisdictions are moving towards integrated responses to health and social inequalities by “joining up” activities across different departments. This should be encouraged and strengthened as health departments have little control over the underlying determinants of social and economic disadvantage. However, it is not clear where coordination and leadership is provided on a whole-of-government basis.

Given their role in shaping the socio-economic environment central departments such as Prime Minister/Premiers and Finance/Treasury could make a much greater contribution and become part of the solution. To assist the reorientation of public policy and programs to reduce health inequalities, a rigorous approach should be adopted whereby all departments are called to account for their actions. A similar approach should be used as for new developments in land use, building, mining etc., where an Environmental Impact Assessment is required.

The planning, development and delivery of health services must also explicitly focus on reducing health inequalities. The availability of services must not exacerbate inequality and be part of the problem—as is currently the case. This is particularly important for Indigenous health, rural and regional Australia, socially disadvantaged communities and access to specialist medical services. All health care organisations at national, state, regional and local levels should develop an explicit plan of action to reduce health inequalities for the populations they serve and the services they deliver. In addition they should make this plan publicly available and report on progress annually. This will mean that new and more appropriate information systems will need to be developed. Primary care could lead this work by building on the experience of the PHC Network. If Australia is to stand taller in health it needs to grow from tearful toddler to strident youth in tackling health inequalities.

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*Health Inequalities Research Collaboration Ministerial Advisory Committee (1999-2004)*

1 <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/hirc-index.htm>

2 [http://www.phcris.org.au/resources/phc/about\\_PHC\\_frameset.html](http://www.phcris.org.au/resources/phc/about_PHC_frameset.html)