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HOW CAN A GOVERNMENT RESEARCH AND DEVELOPMENT INITIATIVE CONTRIBUTE TO REDUCING HEALTH INEQUALITIES?

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The Health Inequalities Research Collaboration (HIRC) is a research initiative to address health inequalities, established in July 1999 by the Commonwealth Minister for Health and Aged Care. Its ability to offer policy options to the government, like similar initiatives in other countries, is circumscribed by numerous factors. They include lack of consensus about the causes of health status differentials, inadequate evidence on how to intervene to reduce health inequalities, and an infrastructure that is underdeveloped in terms of intersectoral action. This article reflects on the work done during the first eighteen months of the Collaboration; on the dynamics that need to be accounted for in any research and development (R&D) response to persistent and growing health inequalities; and on some opportunities offered by the Collaboration in meeting these challenges.

* *The views expressed in this article are those of the authors alone and do not represent the views of the Health Inequalities Research Collaboration Board.*

BACKGROUND

In spite of increasing government expenditures on health systems, health differentials are increasing in many countries. In Australia, health inequalities grew in the 1990s in relation to particular diseases such as type 2 diabetes and circulatory system diseases.¹ Much of the explanation of increasing social gradients in health is focusing on factors in the social environment. Indeed the uneven distribution of behavioural risk factors is argued to result from the uneven—some would say unfair—distribution of economic and social resources; and opportunities such as income, employment, social capital, social support and control in the workplace. In some circles, smoking, drinking too much alcohol and being overweight are explained as individual responses to the absence of resources such as these.^{2–3}

Still, there is much speculation and relatively little evidence about how factors in the social environment, often referred to as social determinants, have an effect on health status. As a result, the Commonwealth Government

is sponsoring an R&D effort to advise it about how to intervene to reduce health inequalities.

THE HEALTH INEQUALITIES RESEARCH COLLABORATION

A renewed interest in the social gradient of health is the context in which the Minister established the Health Inequalities Research Collaboration. The Ministerial Board, responsible for HIRC since March 2000, has determined that:

The goal of the Collaboration is to enhance Australia's knowledge on the causes of and effective responses to health inequalities, and to vigorously promote application of the evidence to reduce health inequalities in Australia.

Furthermore, the Collaboration will aim to:

- facilitate a research program to improve our understanding of the interactions of factors contributing to differences in health status;
- facilitate close collaboration and partnerships between researchers, practitioners and decision-makers;
- encourage synthesis, development and implementation of a range of policies, strategies and interventions to reduce health inequalities;
- inform policy makers and practitioners at all levels of the results of research and its relevance to policy and practice;
- evaluate the effect of policies, strategies and interventions to reduce health inequalities;
- build national capacity for increased research in health inequalities through support of research networks, research methods development, enhancement of data sets, skills development and fellowships;
- monitor trends in health inequalities.

Over the coming years, the HIRC Board will encourage research into the factors operating in three systems considered to be important to health status: families, communities, and primary health care. Each system will become the focus of a network of researchers, practitioners and policy makers. Rural and indigenous health considerations will permeate the Board's deliberations.

CHALLENGES

HIRC is expected to advise the Minister about actions that can be taken to reduce health inequalities. Providing such advice is not simple for a number of reasons, which are equally pertinent to any health inequalities R&D effort:

- While there is general agreement that for most diseases and injuries socioeconomic status (SES) is a risk factor,⁴ systematically intervening to flatten social hierarchies is not generally accepted to be the role of government.
- Consensus among researchers on the relationship between SES and health is not matched with consensus

on the importance of different causal pathways between SES and disease states and thus where to intervene. The journals are currently full of debate about the relative merits of intervening on material, behavioural or psychosocial pathways.⁵⁻⁶

- Most interventions that do occur appear to be on the behavioural pathway and to be generated by the health portfolio.⁷ Neglect of the material pathway is perhaps understandable, when one considers that the portfolios most closely associated with it are taxation, housing, employment and education and the practice of explicit health-related action in these sectors is underdeveloped.
- The commitment to randomised control trials as the principal means for gathering evidence of where to intervene effectively encourages policy inertia because of the enormous difficulties in conducting such studies in the social arena.⁸
- In the meantime, experimentally designed community based interventions and quasi-experimentally based health promotion programs are failing to achieve sustained and equitable outcomes. Community based interventions to reduce cardiovascular disease have produced such mixed results that some are questioning their efficacy as a disease prevention approach more generally.⁸ Health promotion programs have been criticised for being relatively less successful with low SES groups, thereby exacerbating health inequalities.⁷ As a result, we run the risk of practitioner paralysis while we fine-tune intervention designs.
- Finally, the mixed assessments of the health system's role in diminishing health inequalities offer little direction. Recently, Leon et al. concluded their international study with 'per capita expenditure on health does not determine life expectancy'.⁹ While average expenditure may not contribute to health outcomes some argue that the quality of services does contribute to differential health outcomes. There is renewed interest in the values and distributive issues that play a part in the functioning of health systems.¹⁰ Addressing the linkages between equity and health system performance, the World Health Report argued that it is 'not sufficient to protect or improve the average health of the population if—at the same time—inequality worsens or remains high because the gain accrues disproportionately to those already enjoying better health'.¹¹ The moral dimension adds complexity to an already complex scientific arena.

OPPORTUNITIES

Where does a body like HIRC sit in all of this? HIRC does not have a sufficient budget to fund research but it can advocate to grants bodies, like the NHMRC, that strategic research on the social determinants of health be supported. Similarly, it can build capacity in the research community by providing opportunities for research methods

development and for peer support of research. In addition, HIRC will be supporting collaborative and networking efforts between researchers, public health practitioners and policy makers and half of its budget will be spent on the three research networks described earlier.¹²

Like other public health bodies, HIRC remains some years from being able to provide policy options to reduce health inequalities based on widely accepted standards of evidence. So what can bodies like HIRC and health departments do now to reduce the gap between what we already know and what could feasibly work? We would argue that the steps are straightforward, while not being necessarily easy to adopt as a package because of the many players who would need to cooperate:¹³

- adopt a long term outlook on addressing inequalities;
- set targets to reduce health inequalities among particular population groups and for particular diseases, and establish sustainable mechanisms to monitor performance against these targets into the future;
- synthesise existing evidence from a range of sources, including the less accessible literature reporting practitioner and policy maker experience, about the intervention mix that has the best chance of altering disease trajectories, and implement programs based on this synthesis;
- tailor interventions for Australian conditions, acknowledging the cultural and political context in which interventions must find acceptance;
- establish machinery to oversight the implementation and coordination of the interventions;
- monitor changes in population health using specially designed social determinants' indicators, acknowledging the secular trends that are occurring.

Much of this relatively simple formula is being adopted in the United Kingdom. At the end of February 2001, the Minister for Health announced two areas in which he expected to see health inequalities reduced by 2010: infant mortality (a 10 per cent reduction in deaths in the first year of life between manual groups and the population as whole) and expectation of life (a 10 per cent reduction in the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole).¹⁴

The pursuit of a couple of realistic targets through specifically designed interventions, which are backed up by national and local health monitoring, should provide

a significant advance on the evidence base about interventions to reduce health inequalities in the UK. A similar effort in Australia could provide a circuit breaker to the policy inertia and practitioner paralysis that is in danger of dominating Australia's efforts to reduce health inequalities.

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