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Measuring and monitoring health inequities: necessary but not sufficient to bring about effective action on health equity

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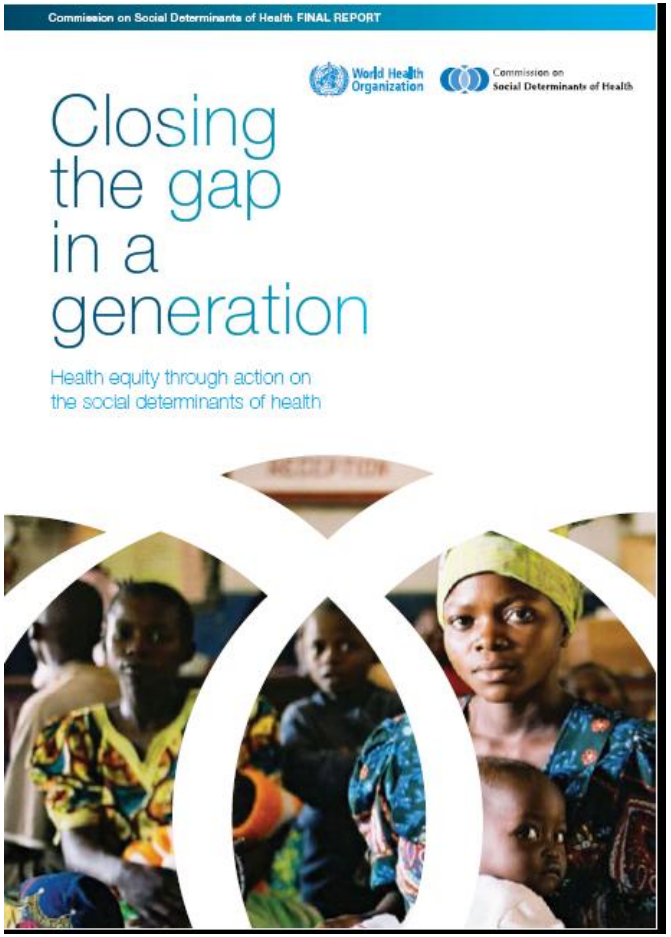
Maternal and Child Health: the Foundations of Population Health
7-8 Sept 2012
Hong Kong

Overview

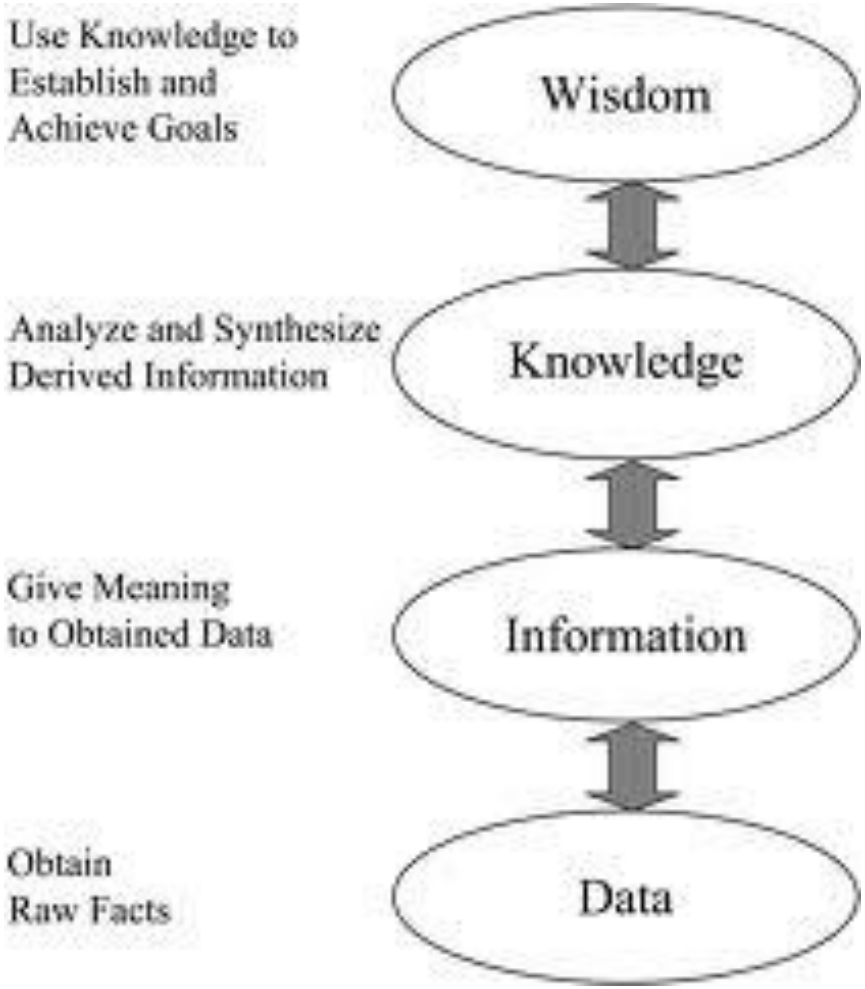
- Need for data, information and knowledge
- Types of data: qualitative and quantitative
- Using data – atlases and on-line systems
- Understanding equity: gradients, gaps and disadvantaged groups
- Understanding population health
- Action requires evidence and political will

Measure and Understand the Problem and Assess the Impact of Action

- Acknowledging that there is a problem, and ensuring that health inequity is measured – within countries and globally –vital platform for action.
- National governments and international organizations, supported by WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health and should evaluate the health equity impact of policy and action.
- Creating the organizational space and capacity to act effectively on health inequity requires investment in training of policy-makers and health practitioners and public understanding of social determinants of health.
- It also requires a stronger focus on social determinants in public health research



Data and information are not enough for action



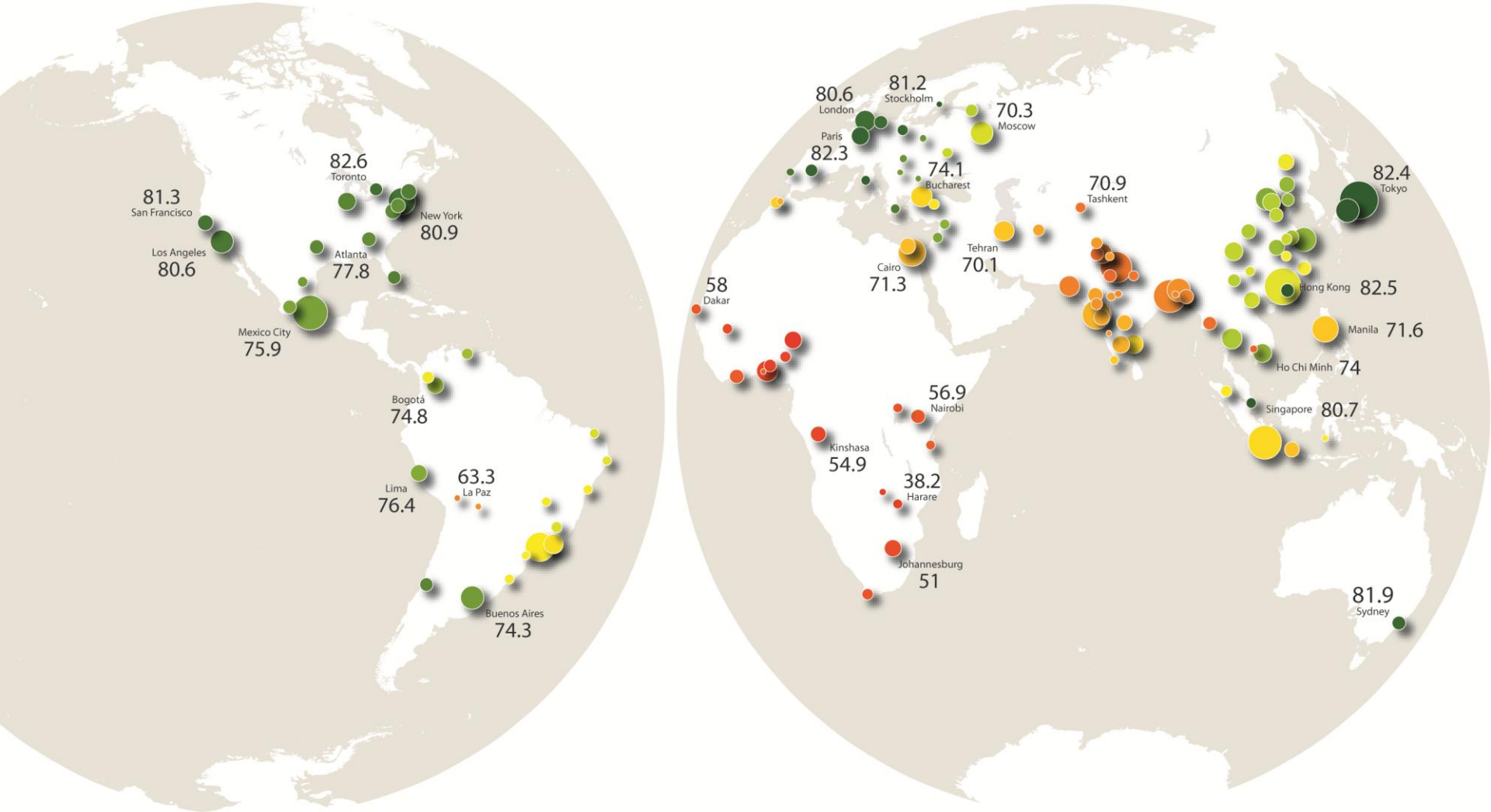
Data and information

Types of data

- Quantitative (extent of a problem/issue)
  - existing data: census, service data, social health atlas, Bureau of Statistics etc
  - survey data
  - before/after measures
  - Comparative statistics (within and between countries)
- Qualitative (building understanding)
  - observation: participant/general
  - Groups (focus, nominal)
  - In-depth interviews

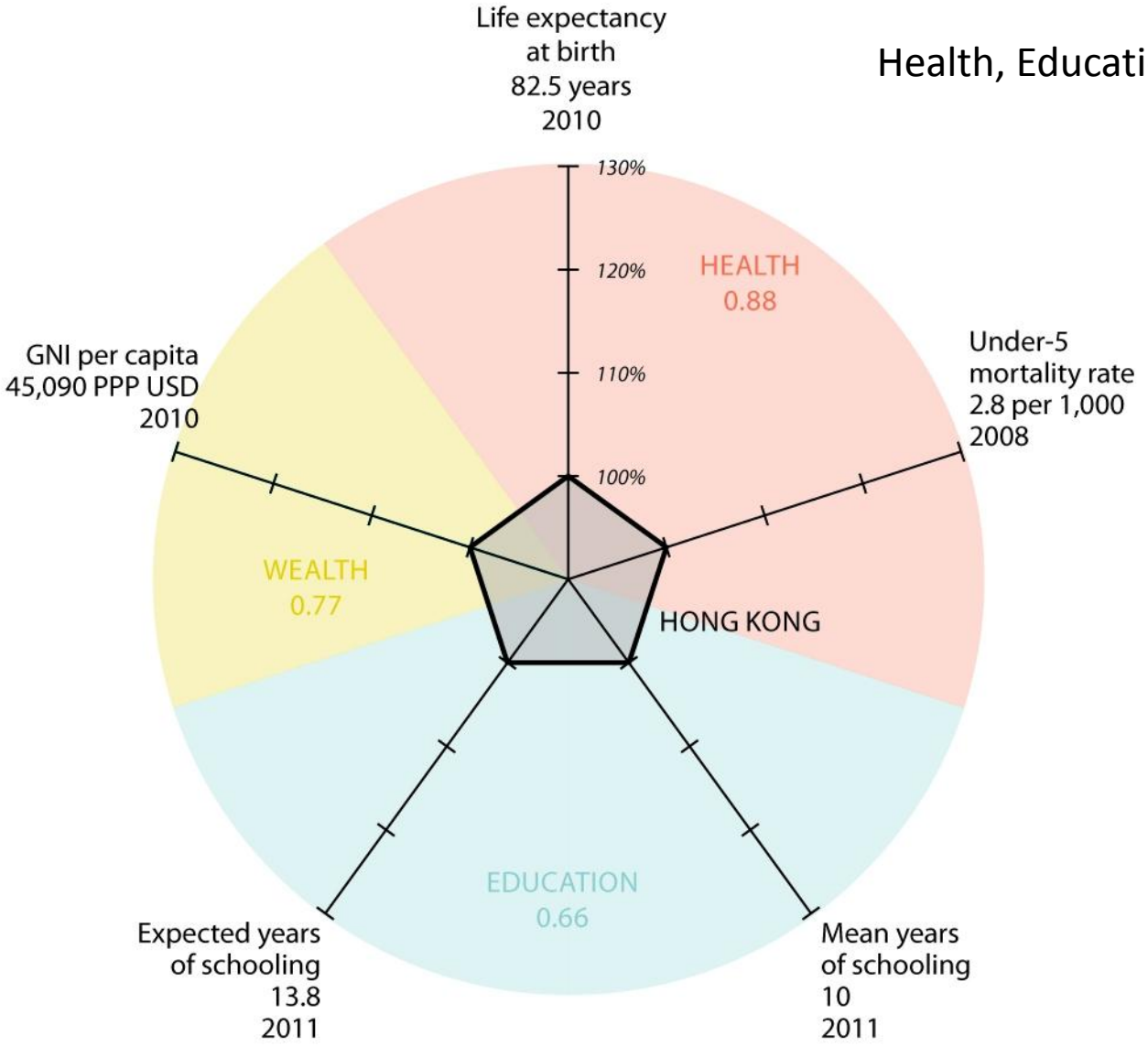
  to gain:
  - insiders perspective(s)
  - process/dynamics of social relationship
  - action within a social context
  - process information to modify intervention

Life Expectancy – cities compared



Paccoud(2011) LSE Cities

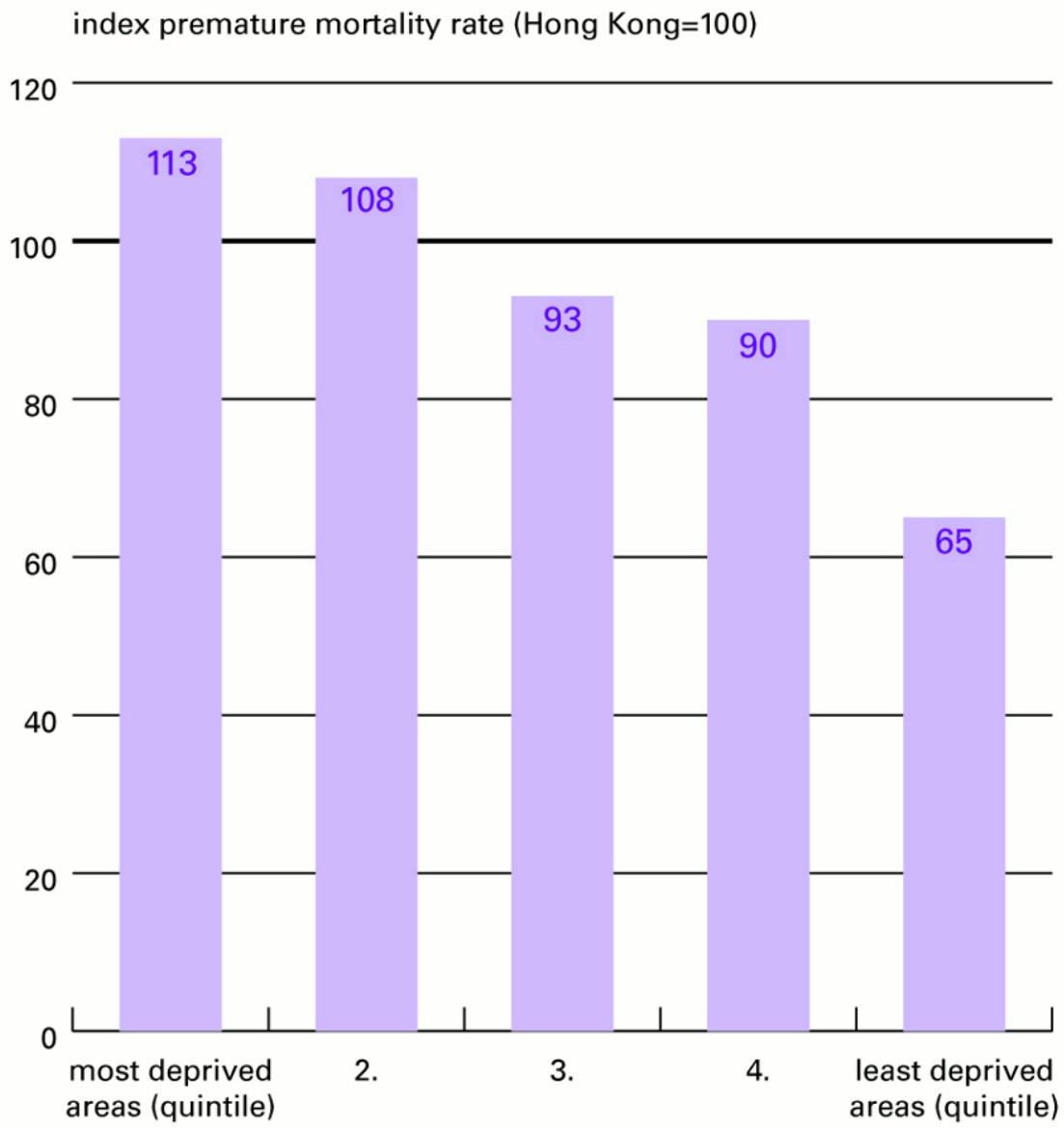
Health, Education & Wealth



Paccoud(2011) LSE Cities

LINKING HEALTH AND DEPRIVATION

Source: Kandt (2011), Cities, health and well-being conference, Hong Kong



Source: Kandt (2011), Cities, health and well-being conference, Hong Kong

Monitoring Inequality in Australia: Australia

Public Health Information Development Unit

Choose an Area

Australia

Choose a Topic

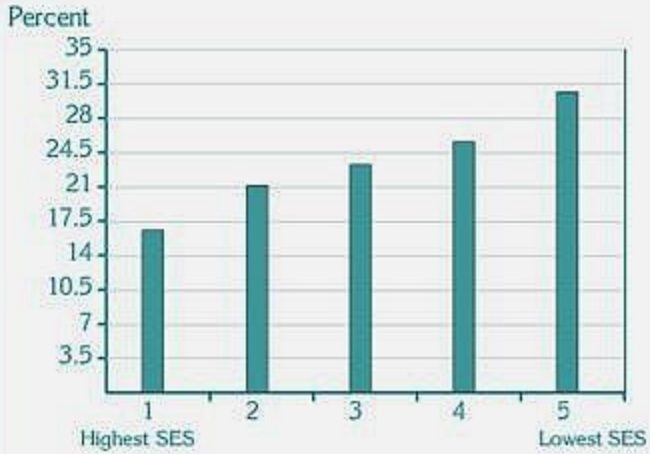
Early childhood development

Choose an Indicator

Early childhood development: AEDI, Developmentally vulnerable on 1

Show/Hide Description

Australia- Early childhood development: AEDI, Developmentally vulnerable on 1 or more domains



Inequality ratio: ratio of Q5 to Q1
2009- 1.86

Quintile of socioeconomic disadvantage of area

The proportion of children assessed as being developmentally vulnerable on one or more domains under the AEDI increases markedly with increasing socioeconomic disadvantage. The overall proportion of children developmentally vulnerable on one or more domains in Australia in 2009 was 23.6%. A strong socioeconomic gradient is evident, with the rate of the children developmentally vulnerable on one or more domains 86% higher in the most disadvantaged areas (30.8%) compared with the least disadvantaged areas (16.5%). Indicator shown is the number of children assessed in their first year of school as being developmentally vulnerable on one or more domains under the AEDI, as a proportion of all children assessed.

LINK TO NOTES AND DATA SOURCES | LINK TO DATA | BUILD SNAPSHOT | PRINT GRAPH

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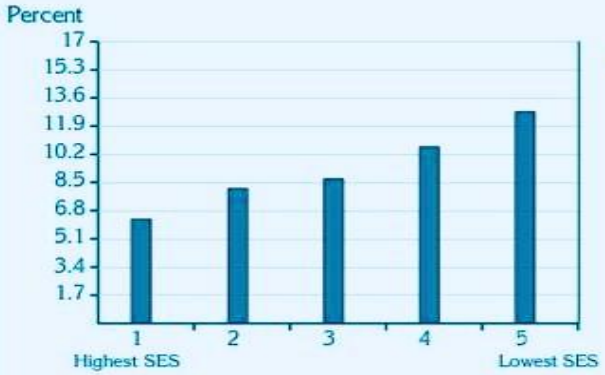
Show/Hide Description

Australia- Early childhood development: AEDI, Physical health and wellbeing: Developmentally vulnerable



The proportion of children assessed as being developmentally vulnerable in the physical health and wellbeing domain increases with increasing socioeconomic disadvantage. The overall proportion of children developmentally vulnerable in this domain in the metropolitan areas of Australia in 2009 was 8.6%. There were more than twice the rate of the children developmentally vulnerable in this domain in the most disadvantaged areas (12.8%) compared with the least disadvantaged areas (6.3%). Indicator shown is the number of children assessed in their first year of school as being developmentally vulnerable in the physical health and wellbeing domain under the AEDI, as a proportion of children assessed.

LINK TO NOTES AND DATA SOURCES | LINK TO DATA | BUILD SNAPSHOT | PRINT GRAPH

Types of Qualitative data

- Indepth, open-ended interviews with individuals or groups
- Direct observations of people's activities, behaviours, actions and interaction
- Written data: organisational documents, clinical or program records, personal diaries, official reports, open-ended written responses to questionnaires.

Patton, M. (2002). *Qualitative Research and Evaluation Methods* (3rd ed.). Thousand Oaks, California: Sage.

Use of qualitative data

- Explain economic, political, social and cultural factors which influence health and disease
- Understand how communities, families and individuals interpret health and disease and how this affects health service delivery
- Elaborating causal hypothesis emerging from epidemiological studies
- Developing epidemiological and health service evaluation survey instruments

Examples of qualitative data

We keep an eye out for one another. You get an offer of help here before you need to ask. (Resident)

People here have to be optimistic - and energetic. They persistently work at making ends meet. People take pride in their environment and value their achievements. (Resident and Salvation Army Worker)

Some local parents … great survivors who work hard to make the best of what they have. They have much to offer each other in terms of role models of perseverance and support. They have a strength of character and an honesty that borders upon the naïve. They want to care for their children and are very protective of them. Their children have a real rough and tumble about them. (Child and Family Health Worker)

Traynor (1990) Measuring the health of a city: A glimpse of the Invisible Christie Downs, Adelaide: SACHRU

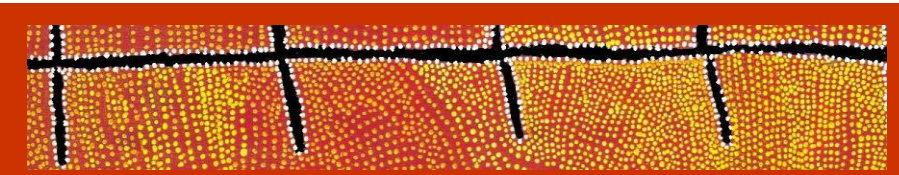
Racism: quantitative data

Racism in at least one institutional setting

(Justice, health, education, government, employment)

Never/ hardly ever	Sometimes	Often/ very often
16	30	54

Source: Zierch, Gallaher, Baum & Bentley, 2001 ANZJPH, doi: 10.1111/j.1753-6405.2011.00681.x



Racism: Qualitative data

- "You could be the only person on the back of the bus and no one will sit with you if you're Nunga…everyone else will stand up around you"(002)
- "If I'm going into the shop and like there might be one or two before me, then about three or four come and then she goes onto them I'll just say 'I'm not just a shadow standing here. I was here before them'" (056)
- "You get called 'black mongrel' when you're walking along' (Mary, 51 yrs)

Source: Zierch, Gallaher, Baum & Bentley, Social Science & Medicine, 2011

Understanding

- Equity
- Population Health

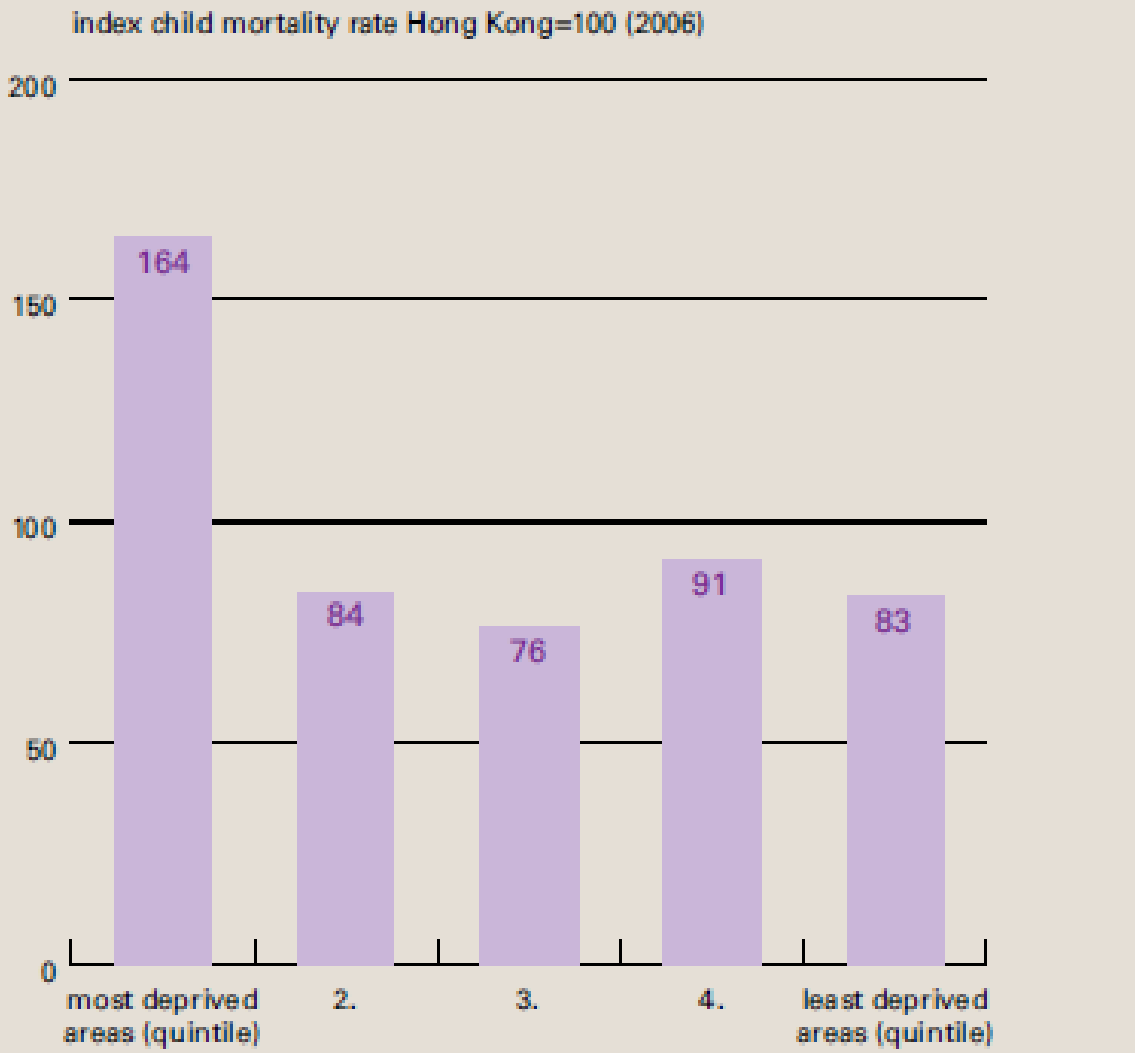
Equity

- Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair
- Health equity would be achieved when unfair differences in health were eliminated
- Equity is about fairness – Equality is about sameness

Goals in relation to equity and population health

- Goals predominantly expressed as gains in **average health** status across the population
- Goals combining gains in **average health status with** gains in **specified target** groups
- Goals combining gains in **average health status with equitable** gains in health status
- Goals combining **equitable gains** in health status with special attention to gains in **specified target** groups
- Goals predominantly expressed as **equitable gains in health status**
- (Dahlgren & Whitehead , 2006)

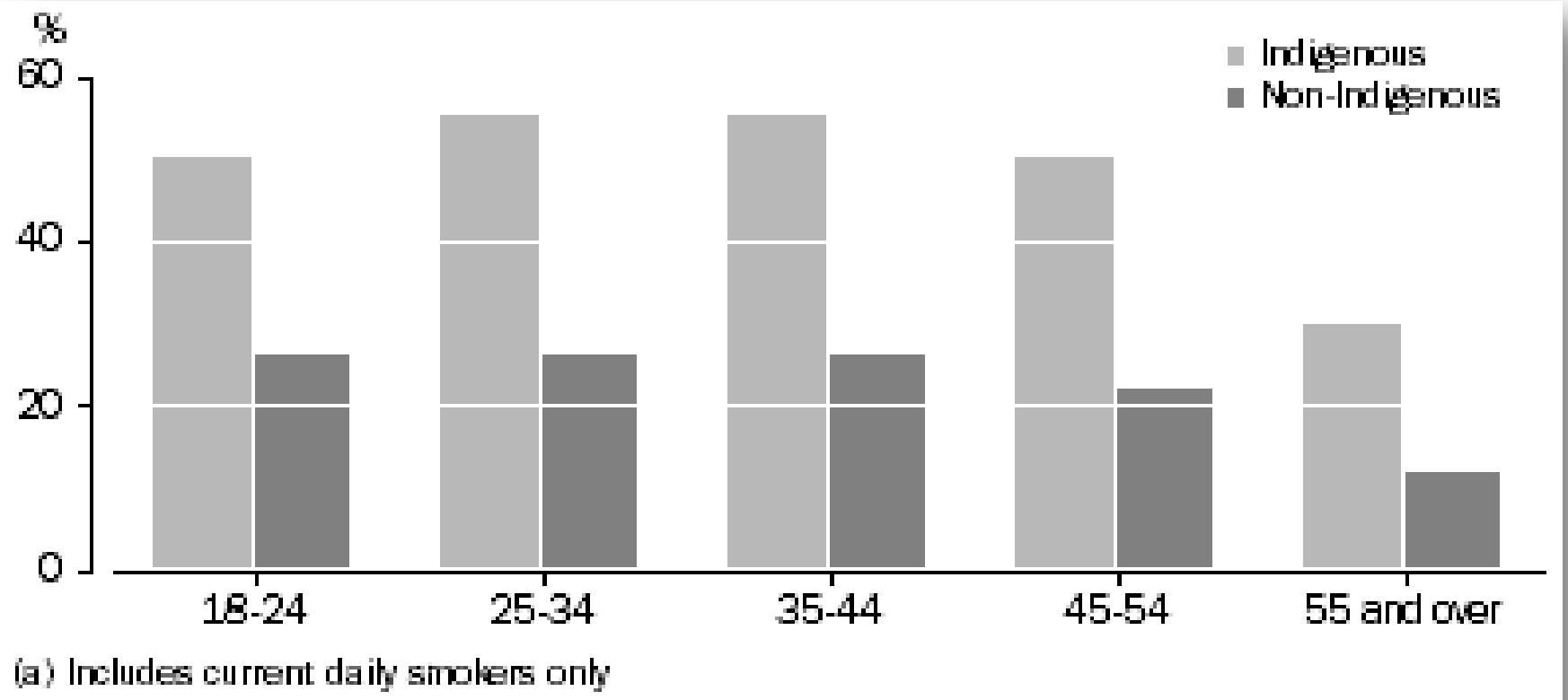
LINKING HEALTH AND DEPRIVATION



Source: Kandt (2011), Cities, health and well-being conference, Hong Kong

Understanding
Asking why is the gradient in Hong Kong flat apart from the most deprived areas?

Indigenous and non-Indigenous daily smokers over 18 yrs by age: 2004-05



ABS Tobacco smoking in Australia 2004-05

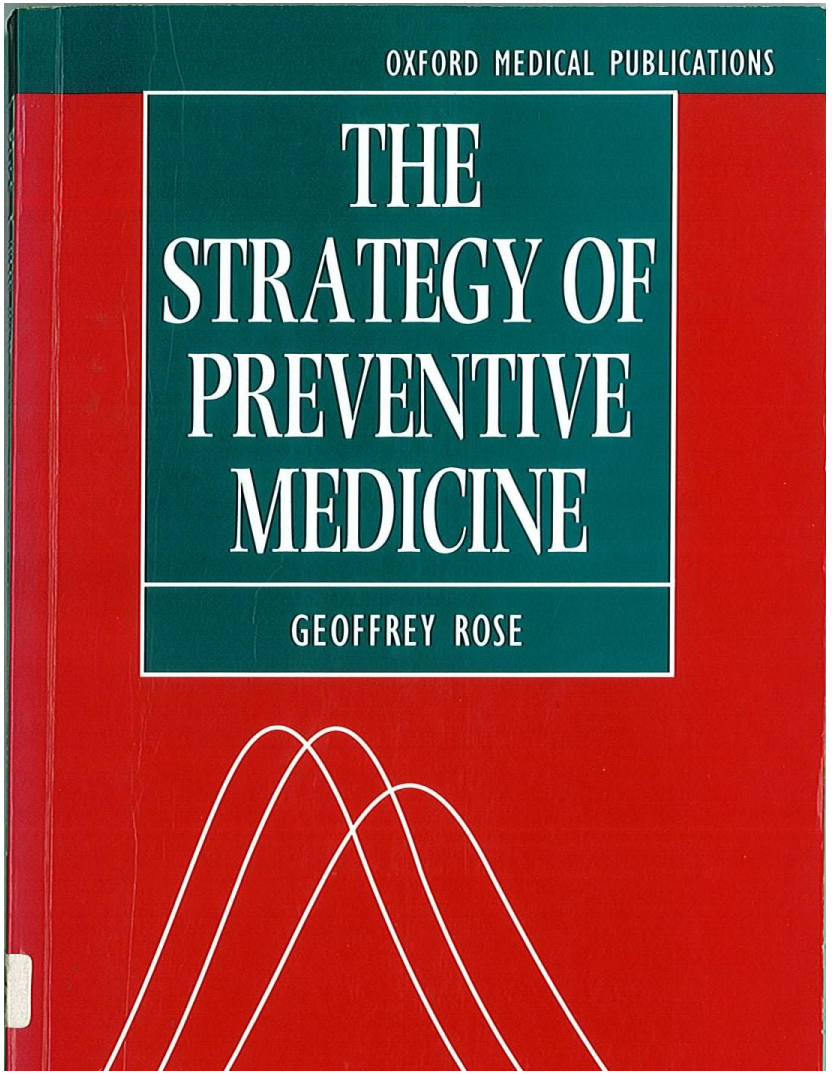
Understanding Tobacco use: Social determinants of being an Indigenous non-smoker (Thomas et al 2008)

- The strongest associations with being a non-smoker are for those not arrested or incarcerated in the last 5 years
- Indigenous people who have not been removed from their natural family are twice as likely to be a non-smoker, to never have smoked or to have quit

Thomas, D.P., Briggs, V., Anderson, I.P. & Cunningham, J. (2008) 'The social determinants of being an Indigenous non-smoker'. *Australian and New Zealand Journal of Public Health, 32.*

Understanding population health

Rose notes that shifts in population distributions may greatly reduce the likelihood of poor health outcomes captured at the tail ends of the distributions **without directing interventions to individuals.**



Example of homicide: Chicago (top) UK (bottom)

Cronin H. The Ant and the Peacock, 1991. Cambridge University Press

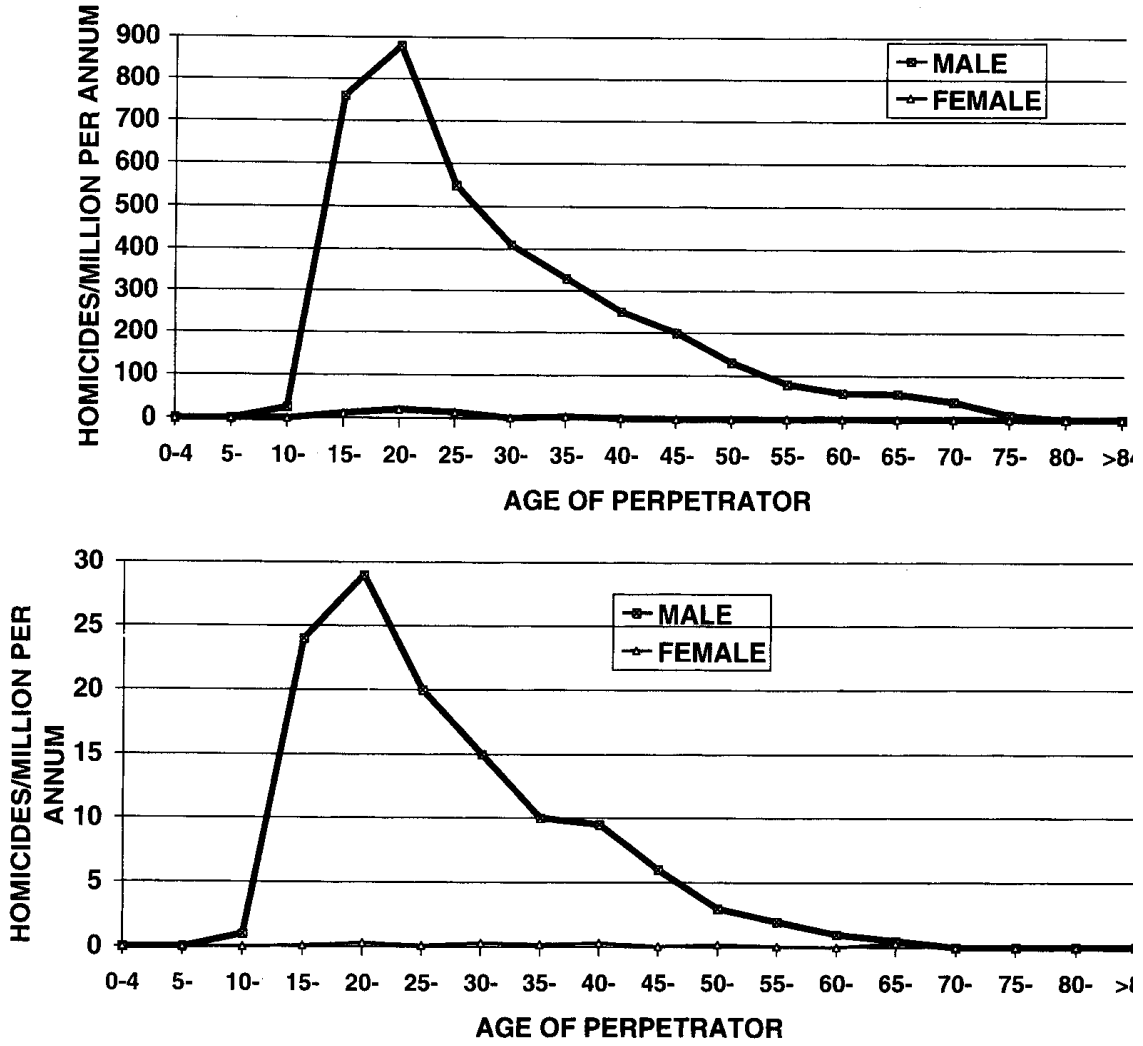


Figure 15–8. Perpetrators of homicide in Chicago (A), and England and Wales (B) (Cronin 1991).

Risk factors for homicide

- **Within countries:** age, sex, family history, genetic etc i.e. focus on individuals

- **Between countries**: legislation, guns, cultural norms etc i.e. focus on populations factors

High risk versus population

Why are some individuals obese?

↓

Focus on clinical/individual solutions

Why so some populations have higher levels of obesity and in others it is rare?

↓

Focus on population wide strategies

Achieving equitable improvement in population health needs to be concerned with both types of questions

Importance of social questions

(After Tesh, 1988 Hidden Arguments)

	Individual	Social
Smoking	How can we stop these individuals smoking?	How can we change the social & economic environment so it discourages smoking?
Childhood Obesity	How can we encourage obese children to lose weight?	What social & economic factors mean our community has higher rates of childhood obesity than others ?
Depression	How do we best counsel teenagers with depression?	Why have rates of teenage depression gone up in our community in the last 10 years? What can be done to change this across community?
Youth Suicide	How can we prevent a depressed young person committing suicide	Why does our society have higher rates of suicide than other societies?
Gun ownership	How can we educate people to be responsible gun owners	What legislation can we pass to reduce gun ownership?

Knowledge and
wisdom to act wisely

Evidence is never enough…..

"inequity (of health or otherwise) is a moral category rooted in values, social stratification, embedded in political reality and the negotiations of social power relations".

Monique Bégin, former Canadian MoH, CSDH Commissioner

Political will to act on inequities

- Requires willingness to act
- Understanding of the social determinants of health and health equity
- Acceptance that action is possible to reduce inequities

Necessary building blocks

- Good data and information that is accessible to decision makers
- Workforce that understands what improves population health and equity (Rose 101)
- Broad understanding of the social determinants of health
- Moral commitment to equity

Unless data are turned into stories that can be understood by all, they are not effective in any process of change, either political or administrative.

(Duhl Len and Hancock Trevor (1988) A Guide to Assessing Healthy Cities)

Dr. Halfdan Mahler, DG Emeritus addressing 61st World Health Assembly May 2008

So please, allow this old man in front of you to insist that unless we all become partisans in renewed local and global battles for social and economic equity in the spirit of distributive justice, we shall indeed betray the future of our children and grandchildren.

Patron of the People's Health Movement

Reducing health inequities requires consumer and citizen support
Essential to establishing popular support for health equity

(Baum, 2007)

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