Appendices to the Gill Gorham Report

(Volume 1)

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Volume 2

TOWARDS A FRAMEWORK FOR A HEALTH PROJECT IN THE BARKLY REGION.

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> *Developing solutions and strategies that can make a measurable difference to the health of disadvantaged Australians will require a research agenda that involves the most active participation of our communities, and incorporates the best and latest knowledge of those communities and how their health is impacted on by social and economic factors (Turrell et al 2000:xii)*

I would like the working party to consider adopting an overarching framework or rationale for the Barkly Chronic Disease (Renal) case study which is based in the approaches coming out of current thinking in the Social & Economic Determinants of Health literature. In particular I recommend to the Working Party the recently released Commonwealth DHAC Report *Socioeconomic determinants of health : towards a national research program and a policy and intervention agenda* (Turrell, Oldenburg, McGuffog, Dent 2000). I have drawn heavily on this document in this discussion paper. I am assuming that the essence of the arguments concerning the Social and Economic Determinants of health are known to the working party (and see the 'Background' section of Cass et al 2000, and - apparently - two most recent editions of MJA)

What would an S&EDH framework for research include?

The evidence so far on 'best-practice' approaches to tackling inequalities in health suggests that the following are necessary components (Turrell et al 2000:91):

1. social ecological principles	*understanding the particular contexts of life/work & how these affect psycho-social functioning including health-related behaviours*
2. targetted	*need to identify population sub-groups*
3. intersectoral with community participation	
4. multiple entry points	*working upstream, midstream and downstream*

Adopting an S&EDH approach would see us explicitly address these four components in the way we structure and develop the project.

Because the S&EDH approach strongly emphasises the importance of community participation, as well as intersectoral collaboration, it is particularly appropriate for this project where we want to work at both a regional and community based level.

Using the S&EDH of health as an overarching framework would give us the following three (suggested p.90) questions to build our CRCATH project around. These would be asked in relation to the specifics of the Barkly. Our project would ask:

(a) What is the relationship in the Barkly Region between the socio-environmental characteristics of communities and/or places in which people live and the consequent health risks (specifically renal) at the individual level?

(b) What is the nature of the relationship between income inequality and health inequality (specifically renal) in the Barkly region?

(c) What is the nature of the relationship between adult health (specifically renal, and in the context of the Barkly) and the social and economic conditions experienced in very early life?

In the context of the national Health Inequalities Research Collaboration the CRCATH project would provide a view of the social and economic determinants of health in a specific remote region with a dominant (but not entirely) Aboriginal population. There are many other regions to which such information could be usefully compared, especially in rural NSW, QLD, & WA.

Adopting these (or something similar) as our large scale central research questions would give us a consistent way of framing sub-components (the separate projects we would hope emerge through this project) as well as a way of tying the separate projects together. Furthermore it would give our project a direct link to broader-based national initiatives.

The 'river' of action: upstream, midstream, downstream

Turrell *et al* (2000:84) also provide a useful summary of evidence-based actions to reduce socio-economic health inequalities - i.e points 'on the river' at which work is required. I'm suggesting we also make reference to these in the way we structure the overall project. That would mean we attempt to have some work - IN THE BARKLY - at each of four levels

- macro-economic & social policies
- living and working conditions
- behavioural risk factors
- the health care system

How might that look in the Barkly context?

Given the serious health situation of Indigenous people, the CRCATH can't (I believe) limit its research effort to describing or elucidating the problem. Our research effort would need to include a balance of 'action/evaluative' work with 'knowledge generation' work. We would need to use the project as an opportunity to work with the community to develop interventions which we learn from (action) at the same time as we increase our understanding of the pathways (research).

The suggestions included here are absolutely hypothetical. This would be THE essential negotiation point with agencies in the Barkly about how they would wish to 'plug' themselves in to such an approach and how they would see the priority issues at these action points:

macro-economic & social policies

(This could entail analyses of how state as well as national policies (health, ed, employment) impact on the Barkly and on Indigenous people in the Barkly; this section does not of course need to restrict itself to the situation of Indigenous people)

Living and working conditions

(Any number of possibilities but Julalikari have already expressed their interest in an involvement in the CRCATH project if it allows them to develop their environmental health program; Anyinginyi have a child-care centre through which specific projects re maternal and child health might be fostered,)

Behavioural risk factors

Close work with Anyinginyi to extend, evaluate, support the kinds of programs they have in place; assist Julalikari in its on-going lobbying concerning alcohol availability in the town and similar etc)

The health care system

refer Peter's paper & with a strongly renal emphasis along the lines discussed by Alan Cass, our on-going research towards ways of establishing and evaluation renal services into the local region, establishment of a locally based renal management data base and so on.

An S&EDH framework in relation to the PCDS

Setting our framework within the Social and economic determinants approach can be seen as incorporating the existing PCDS analysis - but it is not the same as the PCDS. However there is no contradiction. The PCDS (1999 Version) treats 'underlying determinants of health' as one of six "Key Result Areas[1]" which have been chosen or highlighted on the basis of evidence available. However the pragmatic choice of 'interventions' as the primary reference point around which evidence was initially selected and perused has - in effect - weakened the links between the PCDS and the analytical consideration of the causes of ill-health. The CRCATH as a research institution (I believe) needs to have a clear emphasis on elucidating as well as analysing the linkages between the underlying causes of ill-health and the actual patterns of illness (as well as evaluating any interventions to alter the present situation).

The PCDS clearly acknowledges *that diseases and their risk factors are also inextricably linked with the broader socio-economic determinants of health and quality of life, particularly education and employment* (Exec summary) however the overall strategy itself is not set explicitly within this context but within a framework that proposes - again on largely pragmatic grounds - to work primarily at three intervention points: prevention, early detection and best practice management. It then proposes key result areas for each of these: 4 in prevention, 1 detection and 1 best practice management. While the PCDS stresses the

[1] A 'key result area' is defined (p5) as "one for which there is strong evidence to support intervention, but as yet insufficient evidence to define all the precise interventions that constitute a complete program leading to health gain."

need for integration, community participation etc it also notes that evidence for effective interventions for these more complex processes is thin on the ground.

In summary then, adopting an S&EDH approach will have several advantages:
It is explicitly concerned with community participation
It is multi-disciplinary in design and so can bring together diverse research disciplines
It can plug us directly into the the national Health Inequalities Research Collaboration giving us 1) access to their existing expertise in project design and 2) facilitate the development of CRCATH as a centre of excellence for the development of expertise in this particular field concerning Indigenous health.