

# Keynote Speakers



**Mon Sept 11 – 10.10 – 11.00 – Eclipse Room**

## **Shane Houston**

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Professor Shane Houston is a Gangulu man from Central Queensland. He has worked in Aboriginal Affairs for more than 30 years with the majority of that time in the health and employment areas. He has held many positions at local, state, national and international levels including a stint with the World Council of Indigenous Peoples in Canada and as an Australian representative to various UN Forums. He has played a significant role in Aboriginal health over many years through various Ministerial Working Parties and Councils including the National Aboriginal Health Strategy Working Party in 1989. Professor Houston completed his PhD at Curtin University in 2003 graduating with a Chancellor's Commendation.

Shane has worked intensely in the community sector including as a CEO of an Aboriginal Medical Service and National Coordinator of the Aboriginal and Torres Strait Islander Health Organisation.

He has held senior positions in the public sector for more than 12 years including as a Regional Director, a Director of Purchasing, General Manager Aboriginal Health and most recently as Assistant Secretary Aboriginal Health, Family and Social Policy in the NT.

**Wed Sept 13 – 10.00 – 10.50 – Eclipse Room**

## **David Vadiveloo**

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David Vadiveloo is an internationally awarded screen director/producer and nationally awarded human rights advocate. One of Australia's most prolific and successful new independent filmmakers, David's "beautiful and inspirational"\* cross-platform interactive series Us Mob (ABC TV and [www.usmob.com.au](http://www.usmob.com.au)) was the first Indigenous children's project of its type in the world.

David worked previously as a human rights lawyer, notably on Australia's landmark Alice Springs Mparntwe Native Title Claim, and his films have the singular focus of inspiring "agency through screenworks". David established the country's only ongoing 'at-risk' Indigenous youth video training program and his award winning films (Trespass, Beyond Sorry, Bush Bikes, Iwerre Atherrame -two paths) have stirred debate on issues of national significance. David's much anticipated 'Community Prophets Foundation' for at-risk youth is soon to be realised and he remains active as a human rights consultant and speaker.

In 2005 David was the recipient of the Australian Human Rights Award for Individual Community Achievement and was the youngest ever recipient to be Highly Commended for the Human Rights Medal recognising lifelong commitment to human rights.

# Workshops



**Mon Sept 11 – 1.30 – 3.00 – M. Murray**

## **Global Equity Gauge Alliance (GEGA) Workshop**

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This will consist of a GEGA panel that will describe the work of the Global Equity Gauge Alliance through the use of its three pillar approach of Monitoring/assessment, advocacy and community participation; in an attempt to mitigate sociopolitical inequalities and inequities in the health system. There will be short presentations and discussions from the secretariat and three examples of country work.

### **Participants include:**

Noluthando Ngomane, Secretariat – South Africa  
Liliana Jadue, Chile Equity Gauge – Chile  
Frederick Mugisha, Nairobi Gauge - Kenya  
Kausar Khan, Pakistan Equity Gauge - Pakistan

**Mon Sept 11 – 1.30 – 3.00 – H Medlin South**

## **Child Health Workshop** **Convener: Angela Lawless**

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Professor Sue Richardson, Director of the National Institute of Labour Studies at Flinders University and President of the Australian Academy of Social Sciences will explore issues of equity in child health. In many societies the growth of wealth and the apparent improvements in social circumstances have occurred alongside growing concerns about the health and well being of children and youth. Despite the prosperity enjoyed by countries such as Australia, some children are experiencing more disadvantage and more health problems than ever before and the gap between the advantaged and disadvantaged is growing. Why is this so? What can we do about it?

Associate Professor Colin MacDougall will explore the involvement of children in research. Participation has been promoted as a moral and democratic right, a means to improve service quality and responsiveness, a way of improving outcomes for participants and as a philosophical approach to practice. Children and young people remain one of the groups most excluded from mainstream participation mechanisms and marginalized children such as those living in poverty are often least likely to have their voices heard. What are the barriers to children's participation? How can we overcome them?

# Workshops



**Mon Sept 11 – 3.30 – 5.00 – M. Murray**

## **Commission for Social Determinants of Health**

**Convener: Danny Broderick**

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This workshop will describe the work of the Commission on the Social Determinants of Health that was established by WHO in March 2005 and will run until 2008. Fran Baum is one of the Commissioners and will open the workshop with a description of the Commission's work and some of the challenges it faces.

One of the key strategies of the Commission is the establishment of Knowledge Networks that have been charged with the task of summarising knowledge on what works to ensure social determinants promote health and equity. The work of three of the knowledge networks will be presented: Globalisation (Prof Ron Labonte, University of Ottawa, Canada), Gender (Prof Helen Keleher, Monash University, Melbourne) and Urban Settings (Dr. Soichiro Iwao, Director WHO Centre for Health Development, Kobe, Japan). Each will make a presentation on their knowledge networks. The workshop will provide time for discussion and debate among participants about the ways and means of bringing about action on social determinants or health and equity.

**Tue Sept 12 – 9.30 – 4.00 – M. Murray**

## **Indigenous Health**

**Conveners: Ian Anderson and Gavin Mooney**

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### **Session I – 9.30 – 11.00**

9.30 – 9.40	Introduction
9.40 – 10.10	The State of Australian Aboriginal Health <i>Heather D'Antoine and Kim Collard</i>
10.10 – 10.30	Australian Aboriginal Health Policy <i>Shane Houston</i>
10.30 – 11.00	Discussion

### **Session II – 11.30 – 1.00**

11.30 – 11.40	Where did we get to in Session I ?
11.40 – 12.40	Reflections from elsewhere <i>Bernice Downey, Walter Flores, Margo Greenwood, Cherie Kana, Christopher Mushquash, Carolina Valdebenito, Dawn Walker et al.</i>
12.40 – 1.00	Discussion

### **Session III – 2.30 – 4.00**

2.30 – 2.40	Where did we get this morning ?
2.40 – 3.40	How best to build international action and contacts? General Discussion but with clear recommendations emerging
3.40 – 4.00	Agreement on draft of ISEqH Declaration on Indigenous Health

# Workshops



**Tue Sept 12 – 9.30 – 4.00 – H Medlin North**

## **Trade and Health Workshop**

**Conveners: Ron Labonte, David Legge**

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The political and economic forces which sustain an unfair global trading regime are powerful determinants of inequity in health. Hundreds of millions of farmers in low and middle income countries are forced off their land into urban slums by European tariffs and US subsidies. Fair trade would achieve resource flows to poor countries far in excess of current 'development assistance'.

While some of the large developing countries (G20) have started to voice the interests of the South at the WTO, several of the rich countries (G8) are moving away from multilateral trade negotiation towards bilateral trade agreements and investment treaties (imposing 'WTO plus' demands on poor countries one by one). Meanwhile the WHO is slowly and carefully accepting a role as advocate and advisor in relation to the trade and health nexus.

Where to from here? Engaging with trade regulation from the health equity point of view presents challenges in policy, campaigning and research.

This all day workshop on Trade and Health will explore these challenges. The Workshop will consist of two parts. Part I in the morning will involve speakers and discussion. We will review the field broadly and focus our attention on 'what next' in policy, campaigning and research. This Part I program will be suited to a wide range of conference participants, from those with limited acquaintance with Trade and Health to those with particular expertise in the field. The Part II program in the afternoon will provide an opportunity for those who wish to commit to working actively in this field to get together to plan for specific research and campaign initiatives.

A small pack of pre-reading for intending participants is available from David Legge ([d.legge@latrobe.edu.au](mailto:d.legge@latrobe.edu.au)).

Workshop organisers and resource persons for the day: Ronald Labonte (University of Ottawa); Sophia Murphy (Institute for Agriculture and Trade Policy); and David Legge (La Trobe University).

**Tue Sept 12 – 2.30 – 4.00 – WP Rogers**

## **Writer's Workshop**

**Convener: Barbara Starfield**

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Dr. Barbara Starfield, Editor of the *International Journal for Equity in Health*, will be facilitating a writer's workshop at the conference. This workshop will consider what editors and reviewers consider when they review submitted papers on equity. The Discussion will be interactive, and based on anonymously-submitted abstracts or introductions to papers on equity in health as they might be or as they have been submitted for publication.

**Pre-registration is required for this workshop.**

# Workshops



Wed Sept 13 – 11.30 – 1.00 – M. Murray

## Arts and Health

Convener: Christine Putland

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### Panel presenters:

**David Vadiveloo, Kristen Lawler, Parvez Imam, Lisa Philip-Harbutt**

The impact of participation in arts and cultural activities on health and wellbeing is becoming recognised throughout the world. Collaborations between health and arts practitioners in community based initiatives designed to promote health and reduce inequities are increasingly common. While media such as theatre, music and dance have all featured strongly in the field of arts and health, the use of 'new media' including screen based (film/video) and the internet, presents new ways of engaging with communities. This workshop will explore the role that 'new media' can play in extending and enhancing the effectiveness of initiatives concerned with health promotion by examining examples of practice. These diverse examples demonstrate how working through art has implications for practice that go beyond the instrumental, opening up creative relationships between research and practice, participant and practitioner. Developments in this field offer new possibilities for participatory approaches to health equity research.

Wed Sept 13 – 11.30 – 1.00 – H. Medlin North

## A conversation with Hugh Stretton - with Fran Baum and Lionel Orchard – Creating Equitable Societies

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Hugh Stretton is one of the most passionate intellectuals arguing for a commitment to equity in public policy in Australia. In his long career he has advocated for fairer cities (*Ideas for Australian Cities*, 1972); argued for equitable housing policy (*Housing and Government*, 1974) and for less emphasis on neo-liberal economic doctrines in public policy (*Political Essays*, 1987); critiqued public choice theory as a basis for public policy (*Public Goods, Public Enterprise, Public Choice: Theoretical Foundations of the Contemporary Attack on Government* with Lionel Orchard) suggested new ways of teaching economists so that equity is a central consideration (*Economics: A New Introduction*, 2000) and, most recently, in *Australia Fair* put the quest for equity at the centre of public policy debates and shown that equitable public policy is achievable.

Fran Baum, a researcher in public health, admires Stretton's intellectual work and see it as one of the important influences on her own thinking. Lionel Orchard shares that admiration and has worked and published with Hugh Stretton. He conducts research in housing policy and wider debates about neo-liberal and social democratic reform. The conversation between Stretton, Baum and Orchard will explore what changes need to happen in public policy in order to achieve fairer outcomes for people. The conversation will cover each of the main social determinants of health inequities including work, housing, child rearing, health and education services, income distribution and the ways in which national finances should be organized to achieve equity. The session is intended to be participatory and will be a great chance to engage in debate and discussion with one of the most eloquent and compelling defenders of fairness in public policy.

# Guest Presenters and Performers



**Mon Sept 11 – 8.30 – 9.30 – Eclipse Room (Welcome Pipe Ceremony)**  
**Tues Sept 12 – 4.15 – 5.45 – Cloister Area - Canadian First Nations**  
**Traditional Healing Ceremony with pipe and sacred fire**

## **Simone Desmoulin**

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Simone Desmoulin, H.B.S.W. has been providing clinical services for 22 years. As an Anishnabwe qwe she is dedicated and committed to improving the range of programming and resources that First Nations require in order that they experience holistic healing, recovery and wellness in their lives. She currently incorporates a balance of traditional social work practices and Anishnabwe traditions to promote healing with First Nations individuals, families and communities.

She has worked in a diverse number of settings which have provided valuable experience working with First Nations people, helping them to address their unresolved issues relating to the traumas associated with the cycle of family dysfunction that is so prevalent in First Nation families. She has been instrumental in developing and delivering programs that address sexual abuse, grief and abandonment, anger management, eating disorders, adult child issues, team building, conflict resolution, suicide, 12-step recovery, and residential school issues.

For the past 8 years, she has been employed with Biidaaban Healing Lodge as Senior Counsellor. She currently specializes in counselling services which address unresolved issues stemming from the traumas associated with family violence, substance addictions, neglect and abuse.

**Mon Sept 11 – 8.30 – 9.30 – Eclipse Room**

## **Kurruru - Indigenous Youth Performing Arts Company**

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Kurruru meaning 'circle' in local Kurna language is Australia's only Indigenous Youth Performing Arts Company and is committed to providing quality performing arts opportunities for young Indigenous people and their communities across South Australia. Kurruru's home is situated on Kurna land in Port Adelaide (15km north west of Adelaide CBD).

Kurruru Indigenous Youth Performing Arts changed its name from Port Youth Theatre Workshop in 2003 and changed its constitution to reflect the decision undertaken in 2000 to become an Indigenous organisation. Port Youth Theatre Workshop (PYTW) was first established in 1985 to provide recreational programs for young people in the Port Adelaide area to explore and develop theatre and performance skills in a youth friendly and supportive environment.

In 2000, the organisation made the move to focus its programs to particularly meet the needs and interests of young Indigenous people. The change also brought the objective for members of the staff and board to be primarily Indigenous people.

Kurruru offers a jam packed workshop program, has three performance troupes, does annual major performances and has a presence across the state at festivals, community events and through our various partnerships. Kurruru is committed to employing indigenous artists and to providing real pathways, mentoring and training opportunities for emerging Indigenous arts workers. Kurruru is well placed to respond to the demands and needs of its community and is committed to high quality artistic output as tool for social change.

# Guest Presenters and Performers



**Tues Sept 12 – 9.00 – 9.30 – Eclipse Room**

## **Tutti Ensemble**

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The Tutti Ensemble is a vibrant community where people of all backgrounds and abilities can come together, create music and perform with pride. With over half its members identifying with a disability, Tutti is an internationally acclaimed model of integrated arts practice and a truly unique voice in Australian music theatre.

From small beginnings in 1997, when ten intellectually disabled people formed a singing group, Tutti has evolved into a socially and spiritually enriching community of over 100 members with three distinct branches - Tutti Arts, Club Tutti and the Tutti Choir. Together, the Tutti Choir and Tutti Arts perform to thousands of people every year, and hundreds of people regularly participate in Tutti's regional workshops. The success and innovation of this approach has also led to Tutti's role encouraging integrated choral practice internationally. Tutti has established a sister choir in Vancouver, Canada, and will do the same in Glasgow, Scotland in 2006. Stirling University researcher Heather Lynch recently spent a month documenting Tutti's approach to integrated methods of performing arts and choral training.

Over time, Tutti's pioneering work will help to provide a legacy upon which groups and individuals everywhere can build, reframing public attitudes and expectations about disability.

**Wed Sept 13 – 9.00 – 9.30 – Eclipse Room**

## **Kurna Plains Aboriginal School Choir**

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The Kurna Plains School is a Reception to Year 12 school, located in the Playford area in the northern suburbs of Adelaide. It was established in 1986 and is the only metropolitan Aboriginal school in Adelaide. Its stated aims include "strengthening Aboriginality, equality of educational outcomes for all students, academic success, social development, personal worth and life skills." It is open to all students, but caters specifically to the needs of Aboriginal students. It is a school that values tradition while looking to the 21st century. The school teaches Kurna language and culture, as well as the mainstream curriculum.

# Abstracts

listed alphabetically by last name



**Acosta**

Naydu

Tue Sept 12 - 11.30 - 1.00 - Eclipse Room

Javeriana University

Colombia

## 66 PATHWAYS TO ACHIEVING EQUITY IN THE VACCINATION IN COLOMBIA.

**OBJECTIVE:** To identify pathways to achieving equity in the coverage of childhood vaccination between the municipalities of Colombia. The analysis of the factors involved in the differences and low levels of vaccination coverage rates among geographic areas is controversial and there are few studies that analyze the influence of features of the health care system and not only socio-demographic characteristics. The study's purpose is to help health planners and policy makers to develop actions to improve and maintain useful coverage of childhood immunization.

**METHODS:** Analytical ecological study using information from official reports of Colombian states and cities for the year 2003. Three inequity indicators were measured: (1) the coverage gap - understood as the differences between the local and the national coverage rates- by each municipality and type of vaccine, (2) the coefficient of Gini and (3) the curve of Lorenz. Finally, we assess the effects of decentralization, social insurance coverage, government financial resources for public health programs, Unsatisfied Basic Needs Index (NBI) and others socio-demographic features upon municipal coverage gap using a multivariate regression analysis.

**RESULTS:** The national vaccination coverage in 2003 was 78.8%. The number of municipalities with gaps of coverage was high: 603 (54%) of the 1116 municipalities studied. The coefficients and curves of concentration of the vaccination coverage rates showed inequalities between the municipalities during the year studied: Gini's coefficient was 0.12. Regression analysis showed that coverage gap was significantly and inversely related to decentralization, subsidized social insurance coverage and the governmental financial resources for public health programs. The likelihood of coverage gap increased in rural area and municipalities with high density of children population.

**CONCLUSIONS:** Pathways to achieving equity in childhood vaccination in Colombia include developing governmental actions on decentralization and social insurance coverage. It is also relevant to increase the public funds in rural areas with a high density of children in the population. Decentralization promotes local autonomy to organize and adjust health programs to specific conditions of diverse geographic areas. Besides, subsidized social insurance diminished immunization access barriers for children.

Childhood vaccination has demonstrated high cost-effectiveness and benefits not only for immunized children, but also for society as a whole. It is widely accepted that the population must have access to interventions of proven effectiveness and that the whole health system is responsible for the provision of these services.



**237**     *TOWARDS EQUITY IN HEALTH FOR GAY MEN IN NEW ZEALAND & BEYOND*

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This paper explores the issue of inequity in health status for gay men in New Zealand (NZ) (and elsewhere) and addresses potential and actual pathways to equity. For the past two decades gay men's health (GMH) has necessarily required a focus on HIV/AIDS, and it is only relatively recently that disparities between the health of gay men and that of men in general have been given attention by mainstream health organizations and gay community groups. These disparities suggest that the health issues of gay-men-as-a-group need to be addressed separately from health issues of men-as-a-group. The paper argues that despite 'tackling of inequities in health' being a key goal of the NZ Health Strategy there is relatively little concern or interest with health for gay men in NZ (beyond HIV). Three contrasting data sets – selected international policy documents addressing GMH, interviews with key informants involved in GMH from New Zealand, and focus groups with gay men – are used to consider the framing of gay men's health as a public health concern. The critical review of the policy documents identifies that internationally a range of organizations have addressed GMH issues. This is found to contrast markedly with the situation in NZ where there has been limited policy work around such issues. The international policy documents reveal a diversity of voice as to who contributes to the official framing of gay men's health issues, with two patterns (inclusion and exclusion of gay voices) being found. In NZ, in contrast, there is little interest in these issues from key informants from mainstream health organizations/settings and from gay community organizations. While policy development internationally is based on a range of research evidence, the key informants identified a need for 'robust local evidence' before any focus on gay men's health issues would be possible – but simultaneously identified serious research gaps within NZ. One key issue in the analysis of focus group data is that while gay men draw heavily on a 'we are the same as straight men' discourse, they identify a number of gay specific health issues and identify social causes (such as discrimination) as the main factor contributing to poor health and wellbeing. The paper concludes by highlighting factors that can facilitate the development of gay-focused health policy and also introduces two policy development initiatives (from New Zealand, 2006 and Australia, 2003) which aim to improve equity in health for gay men.

## 110 Overall Health Status and Social Capital in South Australia

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Data collected using the South Australian Monitoring and Surveillance System (SAMSS) regarding overall health status (SF1) for adults aged 18 years and over, were analysed by socio-demographic variables to examine health inequities associated with overall health status.

A single question asking respondents to rate their general health is increasingly being used in population surveys as an indication of overall health status. Responses to the SF1 give an holistic indication of the health and wellbeing of the individual.

SAMSS interviews are conducted every month with approximately 600 people of all ages using Computer Assisted Telephone Interviewing (CATI) technology. SAMSS is a cost effective, monitoring system on key indicators. The regular collection of this information provides an understanding of the changes in health and risk behaviours in the general population. From 2003 to 2005, a total of  $n = 15893$  interviews with respondents 18 years and over were conducted, with an overall response rate of approximately 70%.

A number of questions are also asked in SAMSS regarding social capital. Social capital generally relates to the non financial resources available within a community or a family such as the collective value of all "social networks" and the inclinations that arise from these networks to do things for each other. A number of questions are asked in SAMSS to establish levels of social capital regarding trust, safety and locus of control, within the South Australian community.

In 2005, 19.8% of SAMSS respondents reported their overall health status as "Excellent", 36.5% reported "Very Good", 27.9% reported "Good", 12.0% reported "Fair" and 3.8% reported "Poor" health. "Fair or Poor" health was reported by a statistically significantly higher proportion of South Australians who felt that their neighbourhood was not a safe place, who did not feel safe in their home, and who did not feel they had control over life decisions.

Differences between socioeconomic groups with low levels of social capital have also been found. From 2003 to 2005 respondents who were of lower socioeconomic status as measured by SEIFA reported statistically significantly higher proportions of "Fair or Poor" health when they felt that their neighbourhood was not a safe place, however this was not the case for those of high socioeconomic status.

Health promotion, prevention and education efforts should be directed toward the improvement of the health status of groups with lower socio-economic status who may also be lacking in social capital.

156 *Fluoridation of public water supplies in remote Australian Aboriginal communities: a feasibility study*

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Fluoridation of public drinking water supplies is well established as one of the most socially equitable public health measures. However, technological and cost factors have limited the fluoridation of water supplies in smaller and remote communities. Aboriginal children living in such communities have some of the highest rates of dental caries in Australia. Dental caries contributes to the poor state of Aboriginal health in a variety of ways, and fluoridation of water supplies therefore has the potential to contribute significantly to efforts to improve health.

Major objectives of this study include (1) identification of communities that are likely to benefit most from fluoridation of the water supply, and (2) examination of the feasibility and impact of introducing fluoridation plants into two communities.

We have mapped the natural levels of fluoride in the water supply of Aboriginal communities across the Northern Territory (using data from the agency responsible for delivery of water supplies) in relation to the oral health status of children aged 4 to 12 years in these communities (using data from the public Children's Dental Service). We negotiated funding through Territory and Federal agencies for the installation and operation of fluoridation units in two remote communities, and have monitored the operation of these units over a two year period. The units appear to have been effective in delivering fluoride within recommended levels for the majority of this period despite some technical and operational challenges. The dental health status of children will be monitored in trial and comparison communities over a minimum of four years to determine impact on dental caries rates.

The findings from this project will be useful in decisions on the design and operation of these units for use in similar settings across Australia and internationally.

**166 UTILIZATION AND EQUITY OF HEALTH SERVICES IN TWO DISTRICTS OF MOZAMBIQUE**

**INTRODUCTION:** Mozambique is one of the 10 world poorest countries. Life expectancy is 39 years, HIV prevalence 15%, infant mortality rate 107/1000 born alive, maternal mortality 800/100.000 born alive. Access of the poor population to health care services is a fundamental issue.

**GENERAL OBJECTIVE:** Evaluate equity and accessibility to basic healthcare services in two districts of Mozambique (one rural and one urban).

**SPECIFIC OBJECTIVES:**

- 1) measure basic health data in the two districts: (i) children vaccination coverage, (ii) delivery care coverage, (iii) formal health services utilization in case of baby sickness.
- 2) measure inequities stratifying the results by (i) distance from the nearest health unit, (ii) mothers years of school, (iii) socioeconomic status of the family.

**METHODOLOGY:** Basic health survey performed through households interviews. Sampling selection performed through the "stratified cluster sampling method" proposed by WHO to measure vaccination coverage. To achieve statistically significant results ( $p < 0.01$ ) 693 households in the urban area and 600 in the rural were interviewed.

The MICS II (Multiple Indicators Cluster Survey II) proposed by UNICEF was utilized to assess the socioeconomic status of the family (proxy economics indicators). Data analysis was performed using "Statdata".

**RESULTS:** Coverage of all measured services showed to be much higher in urban district than in the rural one. The stratification of the results in the rural district gave these results:

Vaccination coverage: 68% if distance > 30 minutes walking versus 86% if distance < 30 minutes ( $p < 0.001$ ); 73% if very poor family versus 87% if less poor family ( $p < 0.01$ ); 75% if not educated mothers versus 76% if basic educated mothers (not stat. sig.)

Delivery coverage: 46% if distance > 30 minutes walking versus 59% if distance < 30 minutes ( $p < 0.01$ ); 47% if very poor family versus 77% if less poor family ( $p < 0.001$ ); 44% if not educated mothers versus 55% if basic educated mothers ( $p < 0.05$ )

Formal health services utilization in case of baby sickness: 57% if distance > 30 minutes walking versus 76% if distance < 30 minutes ( $p < 0.01$ ); 61% if very poor family versus 88% if less poor family ( $p < 0.001$ ); 63% if not educated mothers versus 65% if basic educated mothers (not stat. sig.)

**CONCLUSIONS AND RECOMMENDATIONS:** Health coverage data of the urban district are, higher than rural one confirming a known "African issue".

Walking distance from the health unit and poverty level of the family seem to play a major role in vaccination coverage, delivery coverage and formal health services utilization in case of baby sickness. Mother education level appears to influence only delivery coverage. Equity and accessibility to basic health care services represent still a main concern. Possible solutions are: building of new infrastructures in remote areas and facilitating of the very poor people to sustain the financial burden of healthcare (mostly transport and loss of income due to missing work).

44 *Equity of health care utilization by the Thai elderly population: Is it worse or better during the unstable economic growth (1991 - 2001)?*  
(POSTER)

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**BACKGROUND:** This research aims to measure inequity in the Thai elderly health care system during different periods of unstable economic growth in the 1990s.

**METHODS:** The concentration index, especially indirect standardized approaches, was used to measure the magnitude of inequalities in morbidity and horizontal inequities in healthcare utilization. The national health and welfare survey (HWS) was the main source of data.

**RESULTS:** It was found that significant chronic morbidity is concentrated in the elderly living with lower household incomes. Income-related inequalities existed in all periods studied, but were lowest in the period after the economic crisis. In all study periods, there was inequity in the use of healthcare facilities. The poor used health centers and community hospitals while the rich used provincial hospitals and private facilities. This trend was more pronounced in the period after the economic crisis. The impact of free services through public health insurance slightly reduced the magnitude of inequity compared with the impact of regional and area differences.

**CONCLUSIONS:** The following are some of the equitable health care policy implications: (i) minimize the gap between the rich and the poor in the elderly health outcome through raising awareness for caring, particularly in childhood. Strengthening employment in the local area might prevent labor migration of young people from their birthplace. Providing an incentive to care at the child's home; (ii) Reducing barriers to accessibility through, for example, cash assistance, village funds, strengthening primary care services, and ongoing monitoring of inequitable health care systems.

**KEYWORDS:** Unstable economic growth, income-related inequalities in morbidity, horizontal inequity in health care utilization, equitable health care policy.

**1.43**     *JUST BETTER PRACTICE FOR COMMUNITY-BASED MEN'S HEALTH*

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**INTRODUCTION:** Promoting men's health in primary care settings such as general practice is now common but what might primary health care for men's health look like in community settings? Claims that men's health is now widely accepted and understood do not acknowledge the inequities between different groups of Australian men. For instance, there is still a seventeen-year difference in average life expectancy at birth between the Indigenous population of Australia and the total Australian population.

**METHODOLOGY:** This paper reports on case studies of diverse community-based health and wellbeing services for men in South Australia. The programs selected as case studies include Aboriginal men, gay men and homosexually active men, men from culturally and linguistically diverse backgrounds, older men, fathers, and young men, as well as childhood sexual abuse and violence intervention services. A case study approach is useful in addressing the complexity of primary health care but the case studies were not intended to be representative of all health programs and services that are provided for men. Interviews were conducted with the people most closely associated with the program or service. Documentation of each case was reviewed and additional insights sought from relevant research. Analysis was conducted throughout the data collection with particular emphasis on checking interpretations with participants and on peer debriefings.

**FINDINGS:** The case studies share the following features – they have a social view of health, address issues of access and equity, use a primary health care approach with an emphasis on prevention, use social justice principles, and work across a number of sectors. These features were integrated into a socially just primary health care framework for men's health in community health settings that is interconnected at social, community and individual levels. Socially just primary health care services advocate social and gender justice and equity at a social level, have a commitment to access and equity, community development, participation, collaboration, and accountability at a community level, and acknowledge a duty of safety, respect, and responsibility at an individual level.

**BROADER IMPLICATIONS:** Socially just primary health care can address health inequities within men's health that are related to, amongst others, class, race, ethnicity and sexuality. Socially just primary health care services can work collaboratively with women's health on common concerns such as violence intervention and childhood sexual abuse. Socially just primary health care services reflect local concerns, where health professionals work with men rather than acting as outside experts.

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**153** *AREA DISADVANTAGE, SOCIO-ECONOMIC POSITION AND CANCER MORTALITY IN AUSTRALIA, 1998-2000*

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Inequalities in mortality (at both individual and area levels), particularly cardio-vascular disease, have been well described however there has not been much attention paid to inequalities in cancer mortality. This is despite the fact that cancer is a leading cause of mortality and is set to increase.

In this paper of working Australian men aged 25-64 in 1998 to 2000, we describe: the associations between occupation and area-level socio-economic disadvantage and cancer mortality for males before and after adjusting for each other and the extent to which there are geographic variations in cancer mortality using a multilevel, binomial logit-link model. We used four primary spatial units comprising the Australian Standard Geographical Classification (ASGC) - States and Territories (S&T) (n=9), Statistical Divisions (SD) (n=59), Statistical Subdivisions (SSD) (n=187) and Statistical Local Areas (SLA) (n=1,3170). Data was organized into cells according to socio-economic position (based on the occupational categories of professionals, white collar employees or blue collar workers) and five-year age group. Socio-economic characteristics of areas were measured using the Australian Bureau of Statistics' Index of Relative Socio-economic Disadvantage (IRSD) categorised into quintiles.

Results indicated cancer mortality was strongly associated with socio-economic position. Mortality was higher for blue-collar workers (RR 1.51, 95%CI 1.36-1.69) and lower for white-collar workers (RR 0.77, 95%CI 0.65-0.92) compared with professionals. A gradient of increasing relative risk of cancer mortality was observed as area-level socio-economic disadvantage increased (after adjustment for within area variation in occupation and age) such that the relative risk of death from cancer increased with each quintile of disadvantage. Consequently, the relative risk was highest for males residing in the most disadvantaged compared the least disadvantaged SLAs (RR 1.46 95%CI 1.33-1.61). The most geographic variation in cancer mortality for males was observed at the State and Territory level. Significant area variation at the SLA and State and Territory level remained after age, socio-economic position and area disadvantage were included in the models.

This study suggests there are significant differences between areas in cancer mortality in working Australian men and that area and individual socio-economic disadvantage explains some of these differences. Therefore, inequalities in cancer mortality should be considered in health inequalities research and policy agendas.

141 *Indigenous health information in Australia, New Zealand, Malaysia and the Philippines*

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**BACKGROUND:** In many countries, indigenous peoples constitute one of the poorest subpopulations. Marginalised socially and economically, their health status is significantly worse than the population as a whole. Good health information, essential to the development of effective health policies and programs, relies on the availability of high-quality data about the health of different subpopulations, including those defined by ethnicity, gender, geography and socioeconomic status.

**APPROACH:** We reviewed the information available on health and wellbeing of indigenous peoples in four countries in the Asia-Pacific region: two with a high Human Development Index or HDI (Australia and New Zealand) and two with a medium HDI (Malaysia and the Philippines).

**MAIN POINTS:**

1. The International Decade of the World's Indigenous People (1994–2004) saw significant advances in international thinking and action on indigenous issues and rights, including the right to health.
2. Indigenous health is adversely influenced by the interplay of several factors including poverty, isolation and inaccessibility, displacement, disruption to traditional ways of living, some traditional health beliefs and practices, and legal and administrative constraints.
3. Sources of data on indigenous subpopulations include censuses, surveys and administrative records. A key, and sometimes contested, issue is the definition of 'indigenous'.
4. Reliable information on indigenous health and welfare is now readily available in Australia and New Zealand, though there are still major gaps.
5. In the other two countries studied, there is a paucity of information in this area. Data collection and statistical capacity are limited and national-level data is rarely disaggregated by ethnicity. In general, indigenous issues receive little attention.
6. Reports based on data disaggregated by indigenous status, as well as other equity stratifiers, can become important public policy and advocacy documents. Statistics must be accompanied by the thoughts and recommendations of indigenous peoples themselves.

**CONCLUSION:** Used wisely, indigenous health information can contribute to reducing the health inequities of indigenous peoples. Documentation of the nature and extent of disadvantage must be followed by targeted strategies, particularly primary care approaches, which are sensitive to culture, gender and human rights issues. Less developed countries can learn from the experience of more developed countries in the region and from each other.



### 33 ACCESS TO, USE OF, EXPENDITURE ON HEALTH CARE IN PALESTINE

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The difficulty of providing health care in Palestine will be obvious: check points and concrete barriers making a ten minute walk into a day's excursion (with no guarantee of successfully negotiating all the obstacles) and the over-riding necessity of prioritizing medical resources for trauma rather than health promotion, all made more complex by a patchwork of provision by a donor-dependent Ministry of Health, NGOs, private hospitals, private physicians, UN Relief Welfare Agency, and the opportunity for 'treatment abroad' (treatment paid for by MoH in a private hospital whether or not actually outside the country). It is difficult to assess what is happening or even estimate the overall volume of expenditure on health care. There is an aspiration to develop National Health Accounts; but only the MoH budget is known with any certainty (c. US\$160million a year including 'treatment abroad').

At the same time, despite the obvious concrete constraints, the Palestinian Central Bureau of Statistics has maintained a programme of excellent surveys throughout the Occupied Territories, so that there is some information which can throw light on volume and especially inequity. In the last couple of years, these include an Access Survey and a Household Health Expenditure Survey; this presentation draws on these two and an administrative database of 'treatment abroad' to document the flagrant inequalities within Palestine.

In terms of Access, the most important findings are the short mean time respondents report that they need to reach health care services; the extent to which the patchwork of provision makes nonsense of any attempt at chronic disease management; and the very large difference in perceived quality between private and public provision both overall and in terms of eight specific dimensions.

Household out-of-pocket expenditure on health care (including medicines) is substantial with the bottom income quintile spending nearly 20% of its overall expenditure on health care compared to about 10% among the top quintile.

The volume of 'treatment' abroad' grew from US\$39million on 18,000 patients in 2003 to US\$60million on 31,000 patients in 2004 and is more likely be used by those from the relatively wealthy governorates.

The story is relatively depressing: the external constraints /oppression is obvious; but there appears to be very little attempt by the Palestinian National Authority or any pressure from the donors to remedy some of the more obvious internal inequalities; or even question the rationale for 'treatment abroad'. Is donor welfarism just perpetuating occupation?

**Carroll, Catherine**

co-presented with Rahel Sebhata

Mon Sept 11 - 3.30 - 5.00 - H Medlin South Room

Dale St. Women's health Centre

Australia

128 *Video Presentation: Improving access for New Arrival Young women to Women's Health Services in Western Metropolitan Adelaide*

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A short video presentation highlights an initiative that supported young African and Middle Eastern women to participate in an intergenerational women's health through arts project.. A youth consultant(originally from Ethiopia) was employed to liase with parents, provide health information and referral, assist with transport and participate in the project alongside local community women.

Dale Street Women's Health Centre(a unit of Central Northern Adelaide Health Service) and Vitalstatistix National Women's Theatre in partnership with Cirkidz, ran an 18 week circus and theatre workshop program for women of all ages in the western area of Adelaide This project aimed to celebrate, inspire and empower women to build community through learning contemporary circus and physical theatre.

This small project within the larger circus and theatre project grew out of community health and development work that uses sport (soccer) and community arts to engage with young Newly Arrived people around their health and wellbeing. Through collaborative partnerships with other government, non government organisations and community members, a small group of youth consultants were employed by Central Northern Adelaide Health Service to work with community health workers in health education and preventative health promotion in relation to harm minimization with drugs and alcohol and safety in relationships. The project also addressed general health and wellbeing, body image issues, building confidence and increasing social networks.

Video was used as an evaluation tool, a medium many young people relate well to in telling their own story.

196 *Age Differentials on Health: An Examination of the Household Effects*

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This paper explores the age patterns on self reported health (health hereafter) by analyzing a data of a national representative sample consisting 35,158 respondents with 13,066 families. In addition to demographic variables, two more types of variables are included for analysis. The first set refers to the level of personal capital and is labeled as personal qualifiers. Personal qualifiers imply the ability to mobilize resources at different stages of life course for men and women. Education, employment status and personal income are deemed to be personal qualifiers. The second set of variables represents social qualifiers embedded in the immediate context of daily life, such as the household. We focus on how personal and social qualifiers mediate the observed gender-age patterns on health. The measure of health is treated as an ordinal variable, and thus ordered logistic regression is performed. The preliminary analyses achieved four major findings as follows:

- 1) Persons are more likely to report ill health as age increases. The relationship between age and health outcomes however is not linear. Persons report better health as they become older in age at a decreasing rate.
- 2) Health do vary according to gender, personal qualifiers and social status (i.e., marital status). Women, persons with fewer schooling, unemployed and low income reported significantly worse health than otherwise. The singles reported healthier than the married, while the married reported healthier than the divorced and widowed.
- 3) Persons also report different health outcomes according to the characteristics of household one dwells, such as family income, household size, number of disabled within the household, numbers of elderly and pre-school kids within the household. Persons living in larger household report better health. Persons living in the household with disabled and the elderly reported worse health than otherwise. Kids under 6 years in age are not a burden, rather an asset to reported health status. The more kids under 6 a family has, the healthier one reports.
- 4) The observed age patterns on health can not be attributable to the difference between sexes, educational levels, and employment status and income levels. Nonetheless, the positive age effect on health outcomes becomes insignificant as marital status is taken into account. To some extent, the positive age effect on health can be partially accounted by the difference on marital status.

195 *Gender differentials, household demands and self-reported health status*

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Although it is generally reported that men have better health than women, little is known about gender differences in the impact of household demands on health, or the potential interaction with educational level, employment status, income level and marital status (i.e. socio-economic position). The objectives of this study are to analyze whether inequality in health exists between men and women, and to assess whether the relationship between household demands and self-reported health differs by gender, while controlling for the effect of socio-economic position. Household demands were measured by household size, living with children under 15 and living with people with disabilities. The data has been taken from the Taiwan Health and Safety Survey conducted in year 2001. A representative sample was drawn. It consists of 13,600 households, and 39,588 subjects aging from 15 to 89 years old. Overall, men (50.8%) report better health status than women (49.2%). After controlling education level, income, age, marital status, employment status and exercise pattern, gender difference in health status still prevails. When we further consider the contextual effect of household demands, it is found that both men and women living with people suffering from disability report worse health than their counterparts. However, when the number of disabled household members increases, women suffer worse health than men. Conversely, household size and living with children under age of 15 have no worse effect on self-reported health for both men and women. Education is still the strongest determinant for self-reported health status for men and women. Single women report better health than widows. Marital status has no effect on men's health, contrary to the general assumption. Social involvement such as being full-time employed is beneficial to both sexes. However, income level becomes insignificant factor for men's health after controlling for household demands. These results emphasize the need of considering the differential impact of household demands on health for men and women. It also suggests that individual-level resources still have significant effect on health even when household contextual effects are taken into consideration.

191 *Working conditions and health among foreign domestic workers in Taiwan*

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Since Taiwan legalized the employment of foreign domestic workers in 1992, the number of these workers has grown substantially. Currently, Taiwan hosts up to 139,000 female foreign domestic workers, most of them are from Vietnam, the Philippines, and Indonesia. Living and working in individual households, these women are away from public oversight and not protected by labor laws, placing them in an extremely vulnerable position.

This study was designed to explore the working conditions and self-reported health status among foreign domestic workers. In the first part of this study, we conducted qualitative interviews with 12 workers, who were recruited through personal networks. The second part was a survey with a standardized questionnaire. Researchers approached foreign workers at social events organized by non-governmental organizations, and invited them to participate in an anonymous survey. A total of 231 women (107 Filipinos, 83 Vietnamese, and 41 Indonesians) agreed to participate and returned completed questionnaires. Information obtained by the questionnaire included averaged working hours per day, days or hours of rest time per month, mental health status, status of burnout, psychosomatic complaints, language ability, perceived employers' attitudes, job satisfaction, and social and demographic characteristics. This study was conducted during the period from February to October in 2005.

We found that women from the three countries had dramatic different cultural and social backgrounds. Interestingly, their health status as assessed by the questionnaire also varied substantially by nationalities. Some women view their work more like a responsibility as a family member and less like paid work, and many of them found it difficult to draw a line between work and their private life. The averaged working hours were 13 hours per day. The perceived attitudes and behaviors of members of hiring families were closely linked to their working conditions, job satisfaction, and health status. The current policies give hiring families an absolute power to determine how to use domestic workers, leaving room for potential abuse. To enhance work and health welfare of foreign workers in Taiwan, we made specific recommendations based on the findings.

105 *THE ASSOCIATION BETWEEN INCOME INEQUALITY AND CHILD MORTALITY HAS BECOME STRONGER AFTER THE TRANSITION INTO A DEVELOPED ECONOMY IN TAIWAN: LONGITUDINAL COHORT STUDY WITH MULTILEVEL ANALYSIS*

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**OBJECTIVE** - Despite a large body of research on whether income inequality in a developed society is an important predictor of population health, there has been few analyses involving time trends. I examined the changing relation between income inequality and child mortality through different stages of economic development in Taiwan.

**DESIGN** - Longitudinal cohort study with multilevel analysis. Data came from the national certificate databases of birth and of death, and the family income and expenditure survey.

**SETTING** - all 21 regions in Taiwan.

**SUBJECTS** - Three birth cohorts of 369,502 in 1980, 326,132 in 1990, and 302,489 in 2000. All birth cohorts were followed up to exactly five years of age.

**MAIN OUTCOME MEASURES** - Under 5 child mortality.

**RESULTS** - The association between regional median share of income and under 5 child mortality, adjusted for father's educational attainment, had shifted from non-significant in 1980 (odds ratio 0.96; 95% confidence interval 0.87-1.07) to highly significant in 1990 (0.94; 0.90-0.97) and in 2000 (0.96; 0.93-0.996).

**CONCLUSION** - Income inequality has become more powerful in determining child mortality after the transition into a developed economy in Taiwan, even adjusting for the socioeconomic position of individual children.

**63 MISSING EARLY LIFE SOCIOECONOMIC POSITION INFORMATION IN SURVEILLANCE: AN ADDITIONAL DISADVANTAGE**

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**INTRODUCTION AND AIMS:** This study examines whether indicators of early life socioeconomic position (SEP) are retrospectively recalled in a population survey, and whether respondents with missing data for these indicators differ from those with no missing data in terms of current socioeconomic circumstances and health outcomes. Measuring SEP across the life course in population health surveillance systems enables trends in the health and SEP of populations to be monitored over time, provides insight into the determinants of health and illness, and influences decisions about government policy and interventions that aim to improve population health status.

**METHODS:** A representative population sample of South Australians aged 18 years and over (n=2999) was asked about their early life socioeconomic position, specifically their maternal grandfather's main occupation, father's and mother's main occupation and highest education level, and housing tenure, family financial situation and family structure when the respondent was aged ten.

**FINDINGS:** The proportion of respondents with missing data was highest for maternal grandfather's main occupation (27.2%), mother's highest education level (20.1%) and father's highest education level (19.6%), lower for family financial situation at age ten (9.0%), father's main occupation (4.6%), mother's main occupation (2.1%), and housing tenure at age ten (1.7%), and lowest for family structure at age ten (0.1%). Indicators of early life SEP are not recalled equally by all population groups. Controlling for all other factors using multivariate logistic regression, respondents with missing data for early life SEP variables were more likely to be older, born outside Australia, of Aboriginal or Torres Strait Islander origin, have a lower education level, a lower annual household income, a poorer family financial situation, a lower status occupation, to not own or be in the process of buying their own home, to be obese, and/or to have fair or poor self-reported general health status.

**IMPLICATIONS:** These data indicate that the respondents whom we are most interested in when examining health inequalities are the very ones from whom we are unable to obtain early life SEP information. Increasing response rates to questions or dealing with missing data for indicators of early life SEP requires serious attention if SEP over the life course is to be measured in population health surveillance systems to produce results that are helpful to policy makers.

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186 *CULTURAL SECURITY: THE ROAD TO EQUITY IN ABORIGINAL HEALTH*

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The concept of Aboriginal Cultural Security is only a recent phenomenon here in Australia. It was the subject of the treatise by the author, Kim Collard, when he graduated from Curtin University with a Masters in Health Economics (Aboriginal). Kim is a Nyoongar man of the Southwest of Western Australia.

Cultural Security has been defined by Houston as ' a commitment that construct and provision of services offered by the health system will not compromise the legitimate rights, views, values and expectations of Aboriginal people. It is recognition, appreciation and response to the impact of cultural diversity on the utilization and provision of effective clinical care, public health and health systems administration'.

Kim's treatise was titled 'Nyeern baarl nidja kwell Cultural Security. Boya kudadjiny' which translated means: What is this thing called Cultural Security? How much would it cost to implement?

Lack of culturally secure health services is probably the biggest barrier for Aboriginal Australians in attempting to use health services.

In his treatise and through a community consultative process, he visited and spoke to Aboriginal community people and staff working in Aboriginal Community Controlled Health Organisation's (ACCHO's). He sought from them what they perceived cultural security to be (in essence the principles underlying it), and what it look might look like in practice. The former is seen to be driven by community values. This is crucial in terms of the communitarian values that underpin Aboriginal culture. It is however all too often missing from the current health services for Aboriginal people in Australia. The latter was more the province of the staff who took the principles elicited from the community and attempted to say how they might be operationalised and what might it cost.

Often cultural security is confused with 'cultural awareness'. Kim's presentation explains clearly explains the difference between the two. Primarily however, the presentation is of his findings in putting flesh on the bare bones of cultural security so that in future health services will not be able to offer the excuse for not implementing it by saying that they do not know what it means in principle or in practice nor what it might cost.



**155 GUDAGA PROJECT: ENGAGING THE COMMUNITY**

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**OBJECTIVES**

The Gudaga project is a cohort study of Aboriginal infants born at a large regional urban hospital. The aim of this paper is to describe our approach to engaging the Aboriginal community in the region.

**METHODS**

All Aboriginal infants born at the hospital are eligible to participate in the project. A ward survey seeks information on the Aboriginal and Torres Strait Islander status of both parents. Mothers agree to three home visits when information on health status and use of health services is collected. A qualitative component is exploring mothers' experiences with health services. We are using multiple strategies to engage the community that build on our past experience of working with the Aboriginal community in the region. These include: employment of an Aboriginal project officer, engagement with the community both formally through the Aboriginal Corporation and informally through other networks, involvement of Aboriginal and non-Aboriginal Health Workers in the Health Service in the local implementation of the project, development of the project visibility through use of recognizable documents, and implementation of mechanisms to provide feedback to the Aboriginal community.

**PRINCIPAL FINDINGS**

In the first four months of the project 450 mothers have been surveyed in the maternity ward and 32 Aboriginal infants identified and recruited to the project. The project has been well accepted within the region

**DISCUSSION**

The Gudaga project is the first study of this kind to systematically describe the health needs of Aboriginal infants in the region.

**IMPLICATIONS FOR POLICY, DELIVERY, OR PRACTICE**

Currently there is little information on needs of Aboriginal children in the region although anecdotal information suggests that these needs are high and that Aboriginal infants and their families do not make good use of services. The project will contribute to the development of services in the region.

**154 EQUITY OF ACCESS TO AND USE OF QUALITY PRIMARY HEALTH CARE**

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**OBJECTIVES**

Currently, primary health care (PHC) is underrepresented in health statistics in Australia and there is limited information on the determinants of access to PHC. This is due to the fragmented structure of the PHC sector and the lack of a comprehensive PHC data collection. This paper examines a theoretical framework for exploring the utility of population health surveys to address questions relating to equity of access to and use of quality PHC.

**METHODS**

Our conceptual framework draws on published literature and management guidelines to identify domains of quality PHC using type 2 diabetes mellitus as an example. We applied this framework to three recent population based health surveys: 2001 National Health Survey, 2002/3 NSW Health Survey, and AusDiab and critiqued data that related to our proposed domains. In developing this framework we also considered appropriate stratifying variables that may influence service utilization. These included demographic characteristics, socioeconomic factors, health status, and behavioral risk factors.

**PRINCIPAL FINDINGS**

We identified seven domains that comprise aspects of quality PHC: prevention, early detection, proactive care, monitoring, complication screening, multidisciplinary care, and outcomes of care, and proposed indicators of each of these. We then critiqued their measurement in each of the survey data collections. No survey sought information on prevention or early detection of diabetes. However, each used similar questions on diagnosis of diabetes. Some information on proactive care relating to cardiovascular risk such as high blood pressure was sought but no information on the management of risk factors such as smoking. All surveys collected comprehensive information on the stratifying variables listed although issues of categorization arose.

**DISCUSSION**

The conceptual framework that we have proposed provides a structure for exploration of equity of access to use of quality PHC. Our critique demonstrated gaps in the current data collections but could show where there were suitable measures patterns of access to and use of PHC demonstrating utility of the approach. We believe that this approach could inform the development of new or alternate questions for inclusion in population health surveys to provide a better understanding of equity of access to and use of quality PHC in Australia. The additional information would extend the utility of population health surveys and complement other routine data collections with a community-based perspective. It would contribute to evaluation of population health interventions through the monitoring of reported health service use over time.

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**102 ARTS PATHWAYS - YOUNG PEOPLE LEAVING CUSTODY**

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This qualitative program of research investigated arts-based practice with high risk young adults in, or transitioning custody. The target group were 16-22 year olds in juvenile custody in Melbourne, Australia. The sentencing hierarchy ensures that young people with custodial sentences are high risk serious and/or repeat offenders. Essentially identical, multifaceted performing arts programs were researched at two gender specific sites, (one male and one female). These sites contain disproportionate numbers of Australian Indigenous, Maori/Pacific Islander, refugee and first generation migrant clients. The research focused on identifying:

- the most appropriate processes for engagement;
- the issues engaged with through the arts and the nature of that engagement;
- whether participants developed key personal, social and developmental skills;
- whether areas of criminogenic need were addressed (substance abuse, particular personality traits, mental, emotional and physical health, violence and self-abuse, offending);
- outcomes in relation to the development of key capacities (confidence, self-esteem, social and communication skills, a sense of belonging) and whether these contributed to the development of pathways for social inclusion; and
- the extent to which any of these vary with gender and diversity (culture/ethnicity).

The research is a comparative, longitudinal, qualitative study conducted over four years of doctoral research (2002–2005), based in the discipline of criminology. The study was funded by the Australian Research Council and 10 industry partners. The substantive interview and observational data offers deep descriptive understandings from multiple perspectives and time periods, of how the program was perceived, utilised and understood, the outcomes that followed participation and the challenges that were faced by the facilitators, young people and custodial institutions.

The research demonstrates that the arts program did engage with many of the key issues but this was dependent on foundational programmatic structures, facilitator qualities and processes. This presentation will briefly outline program elements that enabled engagement and outcomes in relation to health, substance use and criminogenic needs. The main focus of the paper will be to problematise these in terms of long-term change and the development of pathways to social inclusion. Most of these young people's major networks exist outside mainstream community facilities and health services; they have never been integrated with them. The arts program did begin a process of addressing a surprisingly extensive range of needs and underlying issues. However, the research identifies serious potential harms emanating from our current approach to program delivery. Without a sustainable program in a resource rich, fully integrated multi-service environment, the arts may not be 'the magic panacea' for high risk groups that so many researchers and community organisations have tried to promote. This is stark and more complex to address for Indigenous young women, than any other group in the study. The arts can neither do it all, nor do it alone. Can organisations and governments meet this challenge?

**148** *INDIGENOUS RESEARCH PARTICIPANTS' CONSENT FOR LONG-TERM BLOOD STORAGE*

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**AIMS:** Using data from a study of 1,009 urban Aboriginal and Torres Strait Islander Australians (the DRUID Study), we examined participants' choices regarding long-term storage of excess blood samples for use in future studies. Specifically, we examined: 1) the relationship of consent for long-term storage with consent for other aspects of the study; 2) socio-economic, demographic and cultural factors associated with consent for blood storage; and 3) whether participants with stored samples differed on selected health measures from participants whose samples were destroyed.

**METHODS:** DRUID Study participants completed a consent form, then underwent a health examination, including blood and urine collection, clinical and anthropological measurements and administration of questionnaires. For legal and ethical reasons, participants were asked to provide separate consent for various study components. Data were analysed using chi square tests and logistic regression.

**RESULTS:** 55% of participants agreed to long-term storage. Those who provided a blood sample (n=945) were significantly more likely to agree to long-term storage than those who did not (57% vs 28%,  $p < 0.001$ ). Participants who agreed to long-term storage were significantly more likely to agree to allow the study to: send results to their doctor; access their information from various external sources; and make future contact with friends/family and the participant ( $p \leq 0.001$  for each of 9 questions).

Among 875 participants with both a blood sample and a completed questionnaire, consent for long-term storage increased significantly with age but was similar for males and females. After adjusting for age, consent was significantly associated with type of post-school qualifications, household size, private health insurance, reporting having a non-Indigenous grandparent(s), and having the consent form administered/witnessed by an Indigenous staff member.

Never-smokers were more likely to agree to storage than current smokers (age- and sex-adjusted odds ratio 1.6,  $p = 0.005$ ). After adjusting for age and sex, there were no significant differences in storage consent according to diabetes status, body size, hypertension, or self-assessed health status.

**DISCUSSION:** Consent to long-term blood storage for use in future studies was neither rare nor universal among urban Aboriginal and Torres Strait Islander research participants. Decisions about whether to ask for, or to give, such consent must recognize the tension between the ethical principles of justice (maximizing the usefulness of participation and sharing the research burden) and autonomy (participants' ability to determine what happens with their samples).

**202** *Chilean Health Equity Observatory*

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Chile is implementing a profound Health Reform, a process that can be supported by public policies research groups who monitor and analyze its evolution, generating evidence to support the decisions. The Chilean Equity Gauge (CEG) implemented a Public Health Observatory (PHO) aimed to be a tool where all stakeholders interested in health equity will find data and indicators relevant to monitor and evaluate Chilean situation, mainly the Health Reforms and health determinants. Located in the website [www.observatorio.equidadchile.cl](http://www.observatorio.equidadchile.cl), a place where civil society, governmental and all institutions, politicians, academics and the general public can participate to express their opinion and find relevant information. This strategy is a strong advocacy tool, encouraging participation of all actors. To implement the PHO, CEG has collected and systematized databases and other data registered in different public and private institutions and organized them to create the Chilean Health Equity Observatory (CHEO), launched to public access in October, 2005. Its general objective is "To implement a monitoring system for the evaluation and impact of social policies, the health situation and its associated determinants in order to increase health equity in Chile", covering several thematic areas: Health Reform and health system in Chile, Millennium Development Goals for health, Social security and Social determinants of Health.

## Specific objectives

- To monitor the Millennium Development Goals for health.
- To monitor Chilean health policies specifically developed to improve health equity, including:
  - Reorganization of the health system, creation of a new "Health Authority" and networking health services.
  - The Explicit Health Guaranties Plan (EHG Plan or Plan AUGE) implementation and impact.
  - The Equity Objectives defined within the "National Health Objectives for the Decade 2000-2010".
- To monitor, analyze and observe social policies from other sectors in Chile, which includes social health determinants, like "Chile Solidario" and the educational reform, among others.
- To stimulate international support and collaboration within the American region in acquiring and developing knowledge and abilities to improve health information and influence their local context, developing effective health policies.

The analysis and discussions leaded by the CHEO can have an impact and turn into a source of information for all those that contribute in research, generation of evidence and decision making for social intervention and defining the priorities for the health sector, setting the agenda for the country.

**244**     *Personal Empowerment Through Spiritual Healing*

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As we seek to establish equality regarding health access, we must dismiss terms such as Aboriginal and First Nations. We are Indigenous people who are interested in Nation building to restore the languages, cultures, and ceremonial lives of our respective nations.

As Indigenous people we have experienced spiritual disempowerment that has hindered the growth and developmental needs of our societies. As a result of the oppression that occurred with colonization and assimilation, Indigenous people were forced to witness the destruction of societies that were rich in cultural practices and beliefs. This destruction caused many Indigenous people to experience a disconnection from self and the essence of who they are as spiritual beings.

The attempt at colonization, caused many people to lose their connection to the land. The subsequent disenfranchisement resulted when individuals were no longer able to continue practicing their traditional ways of interacting and living in harmony with the land. The roles and responsibilities of each individual were destroyed resulting in a disconnection from self and one's natural gifts and abilities. Community members no longer understood their purpose in life.

The onset of assimilation further destroyed the very foundation of Indigenous peoples. The displacement of children from the family unit caused a disruption in the traditional practices and beliefs of each society. The inherent right to own their voice was taken away from these children. They went from being cherished individuals to institutionalized products of their caretakers. They were denied the right to speak their languages and they were punished for engaging in any cultural practices, beliefs, and customs. The traumas experienced in these institutions further destroyed the essence of who they were as spiritual beings. The residential school experience promoted the dysfunctional rules of "don't talk, don't trust, and don't feel". The dysfunctional family systems were fostered through abuses that impacted the individual physically, mentally, emotionally and spiritually. The generational cycle of addictions, family violence, and abuse was fostered and nurtured as a result of the destruction of the family unit.

In helping Indigenous people heal, one must understand the importance of embracing the cultural practices, beliefs, and ceremonies. Individuals who have experienced a life of trauma are encouraged to embrace their personal power by breaking free from bondage of toxic shame that hinders personal growth and development. They are empowered through the universal teachings of love, respect, truth, honesty, humility, courage, and wisdom. They are enlightened through the teachings that come from attending ceremony, listening to the elders and returning to the teachings of the medicine wheel. They are provided with an opportunity to own their truth, by reconnecting with their discarded selves and embracing the essence of who they are as spiritual beings journeying toward enlightenment.

**57**      *Learning from Action: The use of aboriginal managers' stories as both opportunities for learning and data for research*

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Qualitative research in health service management often relies on informant interviews. This paper outlines an approach to researching Aboriginal management that combined an action learning program with research on the challenges managers in Aboriginal Health Services face. Participants were senior managers in AHSs in Queensland, Australia, and were engaged as co-researchers with a small project team. They participated in a year-long learning program (with an option for academic credit) and presented and discussed their own current management challenges in workshops. Documentation of the management challenges (and the participants' reporting back at subsequent workshops on action taken and results) in the form of stories, constitute the data for this research. The analysis of the data is described, and the validity and applicability of this method for other projects is explored.

## 8 SOCIAL MARGINALISATION: PATHWAYS OF MENTAL HEALTH CARE

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This paper reports two parallel investigations funded by beyondblue The Victorian Centre of Excellence in Depression and Related Disorders.

The first investigation examined consumer experiences of treatment for depression and pathways of recovery. The study centred on how people experience mental health care, specifically 'shared care' and was concerned with how social determinants shaped their care. In Australia, since the early 1990s, the mental health system has been reformed to enhance consumer access to effective treatment. However, many people continue to face individual social, economic and structural barriers to treatment. Social disadvantage, low income, long term unemployment, chronic illness and disability are correlated with high levels of mental illness. People in these groups have the greatest difficulty accessing effective treatment. Data was gathered during in-depth interviews with consumers and service providers. Models of collaborative mental health care were analysed within the context of the key issues consumers identified when seeking treatment. Socially disadvantaged consumers experiences demonstrate that their pathways to recovery were complex and haphazard with little predictability. The treatment many consumers received did not equate to 'care', often they felt unheard, and in some cases dismissed.

International and Australian studies indicate that people who are socially marginalised have impaired access to health and community services and have worse mental health compared with people who are socially well integrated. The second investigation focused on pathways of care for socially marginalised people with or at risk of depression. The study was conducted in two community settings outer eastern metropolitan Melbourne and in Bass Coast in rural Victoria. The study had three main objectives: 1. to identify the mental health care needs of socially marginalised people in the two communities and the barriers to care that may exist for them; 2. to identify the manner in which local primary care partnerships operate and examine ways in which those partnerships and operations may be enhanced to obviate barriers and improve pathways of care; and 3. examine existing clinical and community education and promotional materials addressing depression in order to enhance their applicability and availability to socially marginalised people and care providers. Research into the first two objectives was conducted by semi-structured field interviews with a comprehensive range of service providers and targeted community members. This qualitative research yielded a rich source of data. Research into the third objective was conducted by desk-top evaluation of extant materials gathered from a wide range of mental health service providers, community psychosocial rehabilitation services, the Division of General Practice and from government sources.



**132**     *DEVELOPING A SOCIAL JUSTICE GAUGE FOR A NURSES ASSOCIATION*

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**OBJECTIVES:** Social justice has been identified as a founding pillar of public health and a critical goal of social progress. The first phase of this initiative was undertaken to describe how organizations define and monitor social justice. The aim of the second phase was to develop a social justice gauge and test its utility with board members of a national nursing association that had initiated this work.

**METHODS:** Relevant articles were identified using a prescribed search strategy in seven health and social science databases. Organizational websites were searched. Seventeen semi-structured key informant interviews were completed. Guided by the literature and interviews, a decision-tree model was developed to examine the potential presence of societal health disparities within issues under discussion. The utility of this model was examined by having staff members apply it to several current issues. A social justice gauge was also developed, again guided by the literature and interviews. The gauge was initially applied by research team members to selected position papers of the Canadian Nurses Association. Adjustments were made. The decision-tree model and gauge were then used by board members.

**RESULTS:** Although social justice is a term commonly used in public health discourse, there is still considerable ambiguity both with respect to its definition and its operationalization. Only two existing organizational tools to assess organizational influence on, or alignment with social justice were found. Based on the comprehensive review of the literature and consultation with key stakeholders, two complementary tools were developed: a decision-tree model looking at societal health disparities, and a social justice gauge for examining how well policy and position papers align with social justice ideals. Following its application, the decision-tree model and social justice gauge were adopted by the board of the Canadian Nurses Association to guide future board decisions.

**CONCLUSION:** There is considerable ambiguity surrounding the term “social justice”. An institutional tool, developed to assess social justice in position papers and programs, shows promise as a tool for use by organizations. Further investigation into how health organizations can support social justice and use this institutional tool to monitor progress is needed.

**178 STIGMA IN HEALTH CARE FOR PERSONS LIVING WITH HIV**

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**OBJECTIVES:** The purpose of this research was to explore stigmatizing practices in health care organizations for Aboriginal and non-Aboriginal persons living with HIV and to develop interventions to eliminate such practices.

**METHODS:** A participatory action research design was undertaken. Interviews and focus groups were conducted to explore the experiences of persons living with HIV and health care professionals providing care to people living with HIV. Thirty-three individuals (16 Aboriginal and 17 non-Aboriginal) living with HIV were recruited from hospitals, HIV/AIDS service organizations, and community clinics in Ottawa and Edmonton, Canada. Twenty interviews and two focus groups with health care providers from eight organizations were completed. Community advisory committees provided input on various facets of the study. In-depth thematic analysis was conducted.

**RESULTS:** A conceptual model emerged which highlights sources of inequities in the experience of stigma of Aboriginal and Non-Aboriginal persons living with HIV. Stigma was identified as dynamic and shifting. Stigma was described at five levels of the system: societal, health care environment (organizational, physical and policy environment), client-provider, client-client, and client-community. Embedded stigma was a core element. Embedded stigma is deeply entrenched within the system and reflected in long-standing ways of being, living and working together. Multiple traumas, hierarchies of power and control, and organizational and system co-morbidities were identified as key dimensions of embedded stigma. Nested stigma was another core element. It was characterized by layers of interacting and bi-directional stigma experienced across the system. Relational dynamics, communication and confidentiality issues, and fatigue/weariness were key facets of nested stigma. The facets of embedded stigma and nested stigma crossed all four levels of the system.

**CONCLUSIONS:** Findings highlight several key intervention mechanisms that are needed to address the complex and dynamic nature of stigma, and the multi-level processes that influence the experiences of stigma for person's living with HIV. Core intervention mechanisms to address stigma include cross-system recognition, sensitization and mobilization and advocacy.

**52 ABILITY OF ESTIMATORS TO MEASURE HEALTH' INEQUALITIES**

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**OBJECTIVE:** To examine the ability of Ratio, Risk Excess, Attributable Fraction and Relative Difference to measure inequalities-in-health.

**DESIGN:** Ecological study. Epidemiologic estimators were weighted by population size, and a summary estimation of each one of them was made. Kappa concordance coefficient was used between weighted estimators and weighted Gini coefficients for each of the health outcomes used. Cumulated variance at first factor by principal component analysis was used to determine the ability of estimators of being used in a composite index.

**PARTICIPANTS:** 24 High Income OECD Countries (Countries of the Organisation for Economical Cooperation and Development), according to the World Bank, were selected, between 1998 and 2002. Data were obtained from de OECD Health Data, 2004, 3rd edition. Data about child mortality and Gross Domestic Product (GDP) were obtained from the World Development Indicators 2005, on CD-ROM.

**MAIN OUTCOME MEASURES:** Seven indicators of general health or general disease, six of them suggested in the Millenium Development Goals were included: maternal mortality (per 100000 live births), child mortality (per 1000 children), infant mortality (per 1000 live births), low birth weight (percentage of all live births), life expectancy (years at birth), measles immunisation (percentage of children immunised), DTP immunisation (% of children immunised).

**RESULTS:** Extreme values in health outcome variables used were found. Gini coefficient didn't show an unequal distribution of Gross Deep Product between countries. Weighted estimators ranked in different ways the disparities in health between countries. Ratio and Attributable Risk ranked maternal mortality as the condition with the most disparity, whilst Risk Excess ranked the vaccination programs and Relative Difference ranked the low birth weight as the worst condition. There was concordance in the ranking of inequities among Ratio, Attributable Fraction and Gini coefficients ( $p < 0.05$ ). Cumulated variance in the first factor was higher for ratio and attributable fraction when they were used to build a composite index.

**CONCLUSIONS:** Ratio and Attributable fraction are better than Risk Excess and Relative Difference to measure inequalities in health and to build composite inequity-in-health-indexes.

51 *INEQUITY-IN-HEALTH INDEX: DEVELOPMENT AND VALIDATION*

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**OBJECTIVE:** To develop a new inequity-in-health index (composite), under the assumption of inequity-in-health as “inequality of health outcomes”, using those outcomes proposed in the Millenium Development Goals Indicators to monitor the progress of Millenium Goals (MDG).

**DESIGN:** Ecological Study. Reliability and Validity study of a new bi-dimensional inequity in health index. Principal factor analysis (promax rotation) and principal component analysis was used. Criterion validity was made using Spearman rho, discriminant validity using Kruskal Wallis test , extreme values validity using Chi Square test, and sensitivity to change was made using Kendall tau-b concordance coefficient.

**PARTICIPANTS:** Countries of the world included in United Nations Database. Information obtained from United Nations, World Bank Database, and a non-profit organization (Transparency International) database.

**Main Outcome Measures:** Inequity-in-health index (IHI)

**RESULTS:** A new methodology for building bi-dimensional composites was proposed, which provides graphical and quantitative measure (between 0 and 1 $\pi$ ) of health inequity. Six variables were retained to build IHI: Children Underweight, Children Mortality, Malaria Death 0-4 years age, Malaria Death all ages, Births attended by health skilled personnel and immunization against measles. IHI has high internal consistency (Cronbach's alpha: 0.8504) IHI was reliable (Spearman>0.9, p=0.0000). IHI in the world was 0.3033 $\pi$ , and between countries was from 0 $\pi$  to 0.5984 $\pi$ . IHI had high correlation with Human Development Index, Health-Gap Indicator, Life Expectancy at birth, Probabililty of dying before 40 years age, Gini coefficient and Human Poverty Index (Spearman>0.7 p=0.0000). IHI was able to discriminate countries by Incomes, Regions, Indebtedness and corruption level (Kwallis, p<0.01). IHI identified countries in extreme values too (p<0.005) and showed sensitivity to change (p=0.0000).

**CONCLUSION:** IHI is a bi-dimensional, valid and reliable index to monitor equity-in-health on MDG. A new and reliable methodology for developing bi-dimensional indicators is showed.

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**213**     *THE MDGs AND MATERNAL HEALTH OF INDIGENOUS WOMEN IN GUATEMALA: THE NEED TO INCLUDE EQUITY TARGETS*

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This study used quantitative analysis (descriptive statistics) to analyze the gaps and challenges of the MDGs related to maternal health. Although the indigenous population in Guatemala account for 45% of total population in the country, they suffer poor social indicators to a wider extent than non indigenous population. In this context of social exclusion, there is a need to identify the gaps between subpopulation groups that may be overlooked by aggregated or national targets such as those set by the MDGs. The 'Reproductive Age Mortality Survey' (RAMOS) year 2000, was used to analyze maternal mortality rates (MMR) by ethnicity and educational level. The maternal and child health survey, year 2002, was used to analyze access to obstetric care and other maternal health care services.

**RESULTS**

Although the RAMOS estimated a MMR of 153/100,000 for the entire country, MMR in indigenous women is 3 times more than that in non-indigenous women. In terms of actual deaths counted, 73% of all maternal deaths occurred in indigenous women. In terms of educational level, 94% of all deaths occurred in women (indigenous and non-indigenous) with primary education or less.

Incidence of cesarean sections as an indicator of access to quality of care showed that Only 5% of indigenous women had a delivery by cesarean section where this number was 16% for non indigenous. These figures have remained static for the last 10 years. Provinces with rural indigenous population present up to 30 times more difficulties to reach the network of public health facilities than provinces with urban non-indigenous population. More than 70% of indigenous women deliver at home without the assistance of qualified provider whereas up to 85% of non-indigenous women deliver in a hospital.

**CONCLUSIONS**

There are serious inequities of maternal health outcomes (MMR) and access to obstetric care and other services between indigenous and non-indigenous women in Guatemala. These inequities are not taken into account while setting goals based on national averages and aggregated data. In a context of historical exclusion, MDGs must identify and implement specific targets aimed to reduce inequity gaps. Without the latter, MDGs are contributing to hiding inequities and losing the opportunity to drive resources and efforts towards a wider impact on the health of socially excluded population groups.

74 *Revisiting patient centredness in managing type 2 diabetes: Implications for health inequalities.*

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**CONTEXT:** Type 2 diabetes (T2D) displays significant inequalities (disparities) in prevalence, mortality and morbidity according to social class and ethnicity. Studies suggest management of T2D in general (family) practice may vary similarly. T2D is an 'archetypal chronic disease' requiring complex negotiations about technical and psychosocial aspects of care between general practitioner (GP or family doctor) and patient. How this relationship and negotiation contributes to health and health care inequalities is unclear.

**OBJECTIVE:** To understand how patient centred medicine (PCM) is experienced by patients and GPs in the management of T2D and the implications of this for addressing health inequalities.

**DESIGN:** Qualitative interview study. Analysis based on grounded theory and social constructionism.

**SETTING:** Metropolitan Melbourne, Australia

**PARTICIPANTS:** Patients with T2D and GPs (34 total). Purposive and theoretical sampling.

**RESULTS:** GPs in the study tended to 'problematise' socially disadvantaged patients around a behavioural and individualistic understanding of health. This was centred around difficulties in sharing scientific and rational language and a particular construction of 'autonomy'. Patient autonomy was frequently conflated with compliance and 'non-compliance' regarded as irrational, indicating a lack of agency. In contrast most patients saw themselves as actively self-managing. In this scenario, guidelines sometimes served as a tool for disengaging from patients perceived as problematic. Decision-making was rarely shared overtly. Rather it was most often doctor led. Power sharing was more implicit, and for GPs related more to how problematic they perceived patients. Some resistant strategies also emerged.

**CONCLUSIONS:** There are limits to the way PCM is used in GP and its ability to address inequalities in care. This may have implications for the way clinical care for disadvantaged patients is experienced by both patients and GPs. I propose a model of PCM with stronger foundations in self-awareness and reflection on GP and patient identities. 'Relationship-centred care' and reflexive practice may be more appropriate frameworks for more equitable care.

126 *Culturally safe research with urban Indigenous peoples*

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This paper reports on a study titled - Compositional and contextual determinants of urban health inequities: an Indigenous perspective – and raises some important considerations in the development of culturally safe research relationships between non-Indigenous researchers, Indigenous researchers, and urban Aboriginal and Torres Strait Islander communities.

The study takes place in five contrasting Adelaide postcode areas. These case study areas are different in terms of geography, environment, socio-economic status and levels of social capital. The project aims to examine some of the health inequities facing urban Indigenous people by:

- investigating the compositional and contextual determinants of locational differences in health as they relate to urban Indigenous communities
- exploring the dynamics of the production of health inequities for Indigenous people in five case study areas
- contributing to culturally safe research practices designed to inform policies aimed at improving the health status of urban Indigenous communities
- building the capacity of Indigenous researchers in the development of research skills

Data collection will include detailed individual face to face interviews with 150 Indigenous people and observational data on the five case study areas. The interviews will generate detailed qualitative data and also uses standardised questions to collect data on health, neighbourhood connectedness, perceived racism and perceptions of the impact of whiteness. This paper will reflect on some of the processes and issues associated with establishing an Indigenous study of this magnitude in an urban setting, as well as presenting some early findings. Processes that will be discussed include:

- Community consultations
- Establishment and role of Advisory Committee
- Terminology and Language
- Development of methodological tools
- Participant recruitment
- Funding body requirements

82 *Promoting equity in a community-based health insurance scheme*

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The purpose of this study was to improve the equity impact of a large CBHI scheme (Vimo SEWA) in India. We assessed the distributional impact of the scheme at baseline and end line. Household and member surveys assessed the extent to which members represented the general population, and surveys of claimants assessed their SES relative to that of members.

Baseline research showed that, in terms of membership, the scheme was inclusive of the poorest in rural and urban areas. In terms of insurance utilization, the scheme was equitable in urban areas. In rural areas, however, poorer members submitted a much smaller proportion of claims compared to better-off members. Qualitative research revealed that barriers faced by the poor included poor understanding about the scheme's benefits, lack of ready cash for hospitalization and difficulty in negotiating formal systems.

Based on the qualitative research, we designed and implemented two interventions aimed at improving the scheme's equity. One intervention, "After sales service and supportive supervision" (AfterSS), involved house to house visits to educate members about the scheme, leaving them with a visible reminder of their membership, and with a postcard to communicate with the insurance office. The second intervention, "Prospective Reimbursement" (PR), ensured that members received their claim reimbursement while still in hospital, with a Vimo grassroots worker taking care of the required documents. The research project was carried out as a cluster randomized trial, using a two-by-two design. Equal numbers of clusters were randomly assigned to each of the two interventions, both the interventions together, or "control areas".

This trial demonstrates that, in a community-based insurance scheme in rural Gujarat, neither switching from reimbursement to up-front payment nor strengthening contacts between members and administrators was sufficient to ensure that the poorer members in each sub-district were able to enjoy the greater share of the scheme benefits. Instead, the claims rate increased significantly across the study area, and members in all sixteen sub-districts became slightly less poor relative to the background population. This was in spite of the fact that we achieved high rates of coverage with our interventions, with little leakage from one intervention area to another or from intervention to standard scheme areas. The interventions themselves were designed based on extensive qualitative research about the barriers that might prevent poor members making a successful claim (Sinha, Ranson et al. 2006).

The end-line survey found a significant increase in claims rates across the study area. Claim submission increased as a result of interventions that appear to have strengthened awareness of, and trust in, a CBHI scheme. However, the interventions did not result in a significant increase in claims from poorer members in each sub-district. This may be due to the fact that the interventions addressed barriers faced by the rural membership in general and not specifically the poorest rural members.

This research has important implications for policy and practice in various settings. Even when CBHI schemes are inclusive of the poor, they must be carefully monitored to ensure equitable utilization. Having purchased insurance, poor members in rural areas may require support in order to overcome the barriers they face in accessing health care and submitting claims.



**189**     *"Health Outcomes", appropriate tools to decrease health inequity in maternal care*

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Health Equity is defined as absence of inevitable, unjust, unfair and unnecessary differences in health status across population groups with social, economic, demographic and geographic differences. It is a complex concept that is mainly related to vulnerable groups (such as children, women ...), and usually used by health policy makers.

It is the responsibility of states to provide necessary facilities to maintain an acceptable level of health and well being for all citizens of that state. National Health Systems and Health Care Providers need appropriate models to address this issue. In this study we compare two pregnant women with the same disease, but with different outcomes, in order to introduce our 5 stage model of intervention for decreasing Health Inequity among pregnant women.

The first patient was a 28 year old pregnant woman who died of intrauterine Fetal Death (IUFD) in Kurdistan in 2003, meanwhile, the other patient was referred to a hospital, but with an appropriate diagnosis and adequate treatment, she was discharged in a good condition.

We compared personal and socioeconomic aspects of life of these two patients. We also investigated the interventions by which the outcome of the first patient could have been changed. These interventions can be categorized into five stages chronologically.

- 1-Birth to marriage
- 2-Marriage to pregnancy
- 3-Beginning of the pregnancy to death of the fetus
- 4-Beginning of symptoms to "critical stage"
- 5-Critical stage to death.

Then we wrote down possible interventions in as much detail as possible that could have changed the outcome if they had been applied. Interventions in first stage were mainly changing the patient's background, unlike second stage, that they were targeted to having safer pregnancies, risk factor correction and arranging appropriate health care surveillance.

In third and fourth stage health care providers were perceived have more important role to play as they could screen, diagnose, and manage the patient more appropriately. In the first, second and third stages, interventions are predominantly preventive, but in fourth and fifth levels, they are mostly therapeutic in nature.

This model can be used in most family health care programs, some interventions have a broader field of effect: First level interventions have the potential of improving other aspects of health ( and even life), and 2nd level can decrease mortality and morbidity rates in family planning health care .

**38**      *Role of Economic Inequality and Social Exclusion in the Pace of Health Transition: An Exploratory Analysis for India*

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The concept of "health transition" refers to worldwide increase in life expectancy on the one hand and encompasses the changing configuration of causes of death and pattern of morbidity and resulted in a so-called triple burden of acute illness, chronic illness, and behavioral pathology in the Third World on the other. India is no exception in this regard. Presently, India is facing fairly significant burdens of communicable, non-communicable diseases and behavioural problems simultaneously. The problem would be more acute in the near future and would exert tremendous pressure on health system.

There is an undisputed association between socio-economic inequality, integration and health outcomes. The association could be profound in case of Indian society, which is diverse, multicultural and undergoing rapid but unequal economic growth. Gradual withdrawal of state from various social sectors has also been observed after implementation of structural adjustment programmes in the nineties. The question that naturally arises whether this is the appropriate time of withdrawing state involvement in the health sector also, where high degree of socio-economic inequality exists within population. A natural corollary to the above question is: "is there any variation in the pace of health transition among unequal socio-economic groups?"

Under this backdrop, the present study intends to investigate the changing disease pattern in India by age and by sex during last two decades and whether the ascribed attributes such as religion and caste and the achieved attribute like household economy play a significant role in the changing pattern of diseases over the years. The principal hypothesis of the present study is that the health transition in India, where large socio-economic inequality exists among various sub-populations, is only limited to urban, educated and economically better-off sections of the society.

Data for this study are drawn from National Sample Survey Organization (NSSO) and National Family Health Survey (NFHS) covering the period of last two decades. Some other information is also gathered from extensive review of literature. Apart from showing trend and pattern by age and by sex, multivariate analyses have also been performed to identify the aforesaid attributes.

Pronounced differences have been found in the disease pattern over the years by age and by sex. Significant effects of various achieved and ascribed attributes have also been observed in the changing pattern of disease in the preliminary analysis.

**123**     *Planning for an equitable community: putting equity and social determinants of health on the map of decision makers*

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This paper describes the processes and outcomes of a Social Impact Assessment that was conducted on a major policy document that was released to guide and strategically direct how development will be managed in the Lower Hunter region of New South Wales, Australia. The policy document aims to identify how development in the region will be managed on a sustainable basis based on the potential population increase of up to 125,000 people over the next 25 years. A strategy of this magnitude has the potential to influence the health and social well-being of the people of the region and the equitable distribution of resource and services across the region. In order to identify the potential social impacts arising from the proposed population increase, the Hunter Regional Coordination Management Group (comprising of senior regional managers of government departments) emphasised the need for, and completed a rapid, prospective equity-focused Social Impact Assessment (SIA) on the policy document.

The SIA involved the use of an 'equity lens', to determine whether the impact of increasing population in the proposed development areas would be positive, negative or neutral. The SIA Working Group developed criterion for applying such a lens. Overall, 17 geographical sites were considered in the SIA. A community profile and levels of vulnerability, based on a set of social determinants of health, were established for each site. Both agency based data and additional census data were analysed in order to establish rates of vulnerability for each site. Participating agencies then reviewed current and future service capacity for each site and recommendations according to the identified impacts were put forward to the Hunter Department of Planning.

The LHRS SIA was a worthwhile process in that it:

- promoted the exploration of key determinants of health and social issues to be integrated in policy in a top-down approach;
- enabled the identification of both potential positive and negatives impacts of a policy;
- established a pathway that will be used on an ongoing basis to consider ongoing levels of vulnerability within a community; and
- offered an opportunity for decision makers to examine and ensure that choices they make today do not compromise people's wellbeing in the future and do not increase levels of inequity.

**224**     *Can an International Tobacco Control Treaty Assist in Transforming Gender Relations?*

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Global tobacco use is a critical and growing threat to public health and economic sustainability. In many developed countries, tobacco use has declined, and is now concentrated in vulnerable groups, but gender and diversity are key considerations for developing tobacco control policies and programs. In low and middle income countries, however, tobacco use is escalating across populations, generally with male uptake first, followed by female uptake. Globally, male rates of tobacco use have now peaked and are slowly waning, but female rates are still rising. Currently, 12% of the world's women smoke, but this is expected to rise to 20% by 2020.

The Framework Convention on Tobacco Control (FCTC), the world's first international public health treaty, presents an important opportunity for improving health and preventing future illness, death and economic challenges across a range of signatory countries. Within the FCTC there is a stated concern about the potential for widespread uptake of tobacco use among girls and women in the 21st Century, and a desire for taking gender and diversity into account in the enactment of the various Articles of the FCTC.

Using a gender and diversity lens, this paper analyses current evidence, trends and potential actions linked to several Articles of the FCTC. These include the gendered implications and effects of various components of tobacco control such as tobacco tax and price increases, restrictions on sales and marketing, and policies on environmental tobacco smoke. There are several options to consider when incorporating gender into tobacco programs and policies. While the potential exists for replicating or supporting existing gender inequities through tobacco control, this presentation will outline an argument for integrating gender into the FCTC in ways that transform gender relations and contribute to reducing vulnerability to tobacco by reducing inequities. The implications for maximizing equity and strengthening human and women's rights are explored through using the FCTC.

**243** *'Health Inequities: Aboriginal Perspectives' - WHO Commission on Social Determinants of Health: Overview of Canadian Aboriginal Initiatives*

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At the 2004 World Health Assembly, the World Health Organization (WHO) Director General announced the launch of a WHO Commission on Social Determinants of Health (SDH) to address the growing problem of inequities in health status within and between countries. Over a three year period, the goal of the Commission is to lever policy change by compiling evidence on the science and action on social determinants of health, enhancing societal debate on the topic and proposing global and national policy agendas for action. The Canadian initiative is led by Commissioners, Madame Monique Bégin and Mr. Stephen Lewis. Canada's work is related to the overall goal of the WHO Commission in addressing health inequities, to integrate lessons learned from the Commission into policy processes and to advance dialogue for policy action on the social determinants of health in Canada.

Indigenous Peoples are over represented among the world's vulnerable groups "suffering low incomes, living in poor conditions and lacking adequate access to employment, education, safe water, food and health care service".

Canada had previously undertaken a preliminary analysis on the advancement of the social determinants of health both nationally and internationally which identified that monitoring of Aboriginal health status over time would be an important activity.

An Aboriginal roundtable was hosted by the National Collaborating Centre for Aboriginal Public Health (NCCAPH) on June 29, 2006 in Vancouver, British Columbia.

Recommendations from participant experts were identified in three thematic areas: gathering evidence, policy recommendations and engagement processes. This presentation will provide a more detailed overview of the Roundtable proceedings and recommendations.

**179 REGIONAL INEQUITY IN ADOLESCENTS' MENTAL HEALTH**

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The purpose is to elucidate regional variations in mental health among adolescents and to introduce a measurement model for re-current monitoring of adolescents' mental health that bridges the gap between epidemiological surveillance and health promotion work.

The analysis of regional inequity is based on cross-sectional data from a Swedish county, collected at six points of time 1988 – 2005. In all the sample comprises 17 000 students in Year 9 (15-16 years old) who have completed a self-administered questionnaire anonymously in the classroom. A composite measure of psychosomatic health based on both somatic and psychological complaints is used to examine the regional differences among the adolescents.

The results reveal big differences in adolescents' mental health between the local municipalities. At a general level of analysis the patterns conform to the socioeconomic structures. In municipalities characterised by a high socioeconomic structure, the proportion of adolescents reporting psychosomatic complaints are significantly lower compared to municipalities with a low socioeconomic structure. However, there are also outliers deviating from the general pattern, e.g. municipalities with a low socioeconomic structure showing a relatively small proportion of psychosomatic complaints.

A focus on both invariance and deviations in regional health patterns provides an efficient link to local health promotion work. Interpretations of unambiguous patterns may raise not just structural issues but also questions about which preventive measures that have been undertaken or have not taken place. Health promotion models that combine epidemiology and intervention may also serve as powerful tools in detecting and addressing regional and local inequity in health. In accordance with these experiences, the National Board of Health and Welfare in Sweden has prepared for large-scale nation-wide studies targeting every student in Year 6 and Year 9 every third year. The major purpose of this approach is to enable feed-back of data to communities, in order for the data to be used as tools in local prevention, health promotion, and health planning. The potential of the proposed approach is illustrated in a report from a pilot study carried out in a big city in Sweden where epidemiological data was collected in year 8 and the results distributed across 21 local districts in the city. In the communication process with politicians, other decision makers and stakeholders at schools and local districts there was strong support for the idea to include the pilot data as a part of ongoing work on quality assurance.

158 *Will a focus on the social determinants of health reduce health inequality in Australia?*

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In Australia there is increased discussion of the need for the health system and government to recognize the importance of the social determinants of health. This is often done in the context of taking action to address the substantial health inequalities. In these discussions there appears to be a lack of critical reflection that the forces that drive the unequal distributions of opportunities for health will not automatically be addressed through recognition that urban planning, housing, unemployment, education make substantial contributions to health by other sectors and giving greater priority to these issues in public policy. In this presentation I will use three case studies to reflect on the potential limitations of a focus on the social determinants of health as an effective driver for the reduction in health inequality and examine how the two approaches could be more constructively linked.

Case 1: Health Impact Assessment

A concern for equity is recognized as a basic value of Health Impact Assessment. However a literature review that was undertaken as part of the development of the Equity Focused HIA in Australia found that there were few examples where the distributional impacts of proposals were systematically studied although the wider social impacts often were.

Case 2: Depression: Employed or unemployed the priority population.

Work by Marmott and others have demonstrated the important impact that control within the workplace can have on mental health. However there can be little doubt that the mental health of people who are unemployed is worse than people who are employed. Why then did “Beyond Blue” – an NGO Depression Initiative in Victoria – choose to focus on depression in the workplace.

Case 3: Health Promoting Schools:

In parts of Sydney for some time many Health Promoting Schools Programs had an accreditation systems. Schools were expected to reach a certain standard of performance, demonstrate levels of “School Community” involvement, and commitment of their own resources to the program. Very few of the most disadvantaged schools were actively able to participate in the program due to this lack of capacity.

Why is it that we feel that the social determinants of health is a more effective paradigm for tackling health inequality that discussing the issue of health inequality directly? What are the values that may be driving these differences in perspective? Why do they matter? Is there a way of harnessing the strengths of both perspectives that will lead to effective action.

**1.57**     *Incorporating Equity Consideration into Health Impact Assessment: Lessons from Practice*

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Health impact assessment (HIA) is a structured process that can be used to assess the intended and unintended impacts of policies, programs or projects. One of the major drivers for HIA's use internationally has been as a mechanism to redress health inequalities and ensure the consideration of broader health equity issues.

The New South Wales HIA Project is a multi-pronged capacity building project that aims to integrate HIA into the state health system as a tool to improve internal planning and decision-making and as a mechanism to engage external partners on initiatives which influence health outcomes. Part of the project has involved supporting eleven sites to undertake HIAs. These HIAs have been conducted on a diverse proposals ranging including city-wide urban planning strategies, health policies, physical developments and health service programs.

Despite the historical emphasis placed on assessing whether impacts are unjust, unfair or avoidable as part of HIA, we encountered a number of practical difficulties when trying to incorporate equity considerations into the eleven HIAs completed. Some of these challenges have included:

- Developing statements of shared values for those involved in the HIA so that collective decisions about whether potential impacts are unjust, unfair or avoidable can be made;
- Overcoming the paucity of data on specific population groups, particularly at the local level, that can be used as a basis for impact prediction;
- Deciding whether to take an a priori approach that sets out certain communities, groups or populations to be considered as part of the assessment or an a posteriori approach that seeks to identify groups through the assessment process itself that may be subject to inequitable or unintended impacts; and
- Balancing the competing demands of community involvement and ownership of the HIA whilst ensuring its timely completion;

If HIA is to live up to its promise of making health equity a key consideration in decision-making it is essential that these challenges be overcome. This presentation will put forward a number of practical measures that can be taken to incorporate equity considerations more systematically into HIAs, based on experience with the eleven HIAs conducted so far.



99 *Australian Private Health Insurance: Inclusive and Equitable?*

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ABSTRACT: In Australia, private health insurance (PHI) co-exists with a tax-based universal health care system (Medicare) established by the Labor Party in 1984. In 1997, an Industry Commission report noted that PHI premiums were rising rapidly, fund membership was progressively falling (from 50% in 1984 to 31% in 1997) and the public hospital system was also under strain. Sequential policy initiatives by a Liberal Coalition government included (1) a 30% government PHI premium rebate (from April 2005 increased to 35 per cent for those aged between 65 and 69, and to 40 per cent for those aged 70 or older), and (2) "Lifetime Health Cover" allowing health funds to offer lower premium rates to people entering insurance early in their lives and higher premiums for people joining later supported by a massive advertising campaign.

In response, the coverage of PHI peaked at 45% in late 2000 and more younger people joined the funds. Subsequently, these figures have slowly declined. The 30% government rebate costs about \$2.5 billion annually while the 2005 increase in rebates for the aged has added \$111.3 million per year.

The government argues that these policy measures have provided "private health choice for most Australians". Others are concerned that subsidizing PHI with public money is inequitable. Surveys show that the lower a person's income the less likely it is that they will have PHI, yet poorer people tend to have greater health needs than those with higher socioeconomic status. In addition, there are far fewer private hospitals in the country compared to the cities so that people in rural areas (who also have lower income) also miss out, especially indigenous Australians. Furthermore, people with PHI make more use of health services, probably because of capacity to pay and consumer and supplier-induced demand. Given constraints on health services supply, such as the number of surgeons available, it is likely that services provided for patients with PHI come at the expense of public patients without PHI (but whose needs are greater). Finally, the PHI rebate is regressive, reducing the contribution gap between the rich and the poor.

Given the above, it can be argued that the PHI rebate would have been more equitably spent funding additional public hospital beds for the chronically ill, decreasing public elective surgery waiting times and improving services in hospital accident and emergency centers.

227 *"FROM THE COMMUNITY" HEALTH: NON-STATE COMMUNITY HEALTH SYSTEMS AS A POSSIBLE STEP IN THE PATHWAY TO FUNDAMENTALLY RESOLVING HEALTH INEQUALITIES RATHER THAN AMELIORATE THEM.*

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**PURPOSE:** Health for All by 2000? Rather, health inequalities are growing between developed and developing nations and between social groups within nations. Globalization from above has facilitated the gradual dismantling of the welfare state bringing the commodification of health care and user pays regimes. Much research into health inequalities has been funded but programs lack broad vision, funding, time and, it could be argued, lack of political will from Governments. Furthermore a new dialogue of the primacy of national security, ostensibly against the threat of "terrorism", has emerged, drowning out any other discourse of threats to life and security such as poor housing, dangerous jobs, racism and poverty.

However there is emerging a critique of Human or Health Security counterposed to National Security. Within this context new "From the community health structures" are emerging and old community based structures revitalizing. Reclaiming social space, inclusion, and community empowerment, these structures and systems are global, mobile and diverse; occasionally real-time and occasionally virtual. Autonomous from the State or corporate interests, they can work in the gaps where state sovereignty is weak, they support the most marginalized and often engage and include those excluded by the State such as illegal immigrants, asylum seekers and Sex-workers.

This paper traces some of the history and development of non-state community health structures in the context of widening health inequalities from the Alma Ata and the Aboriginal Health Service, to the modern day, cataloguing some of the lessons learnt in international and Australian examples. Most importantly it proposes a way forward and describes a possible role for non-state community health systems to fundamentally resolve health inequalities rather than just describe or ameliorate them.

**METHODOLOGY:**

Participant observation,  
Critical Review of literature

**MAIN POINTS:** In acknowledging that health inequalities are structural then a critique of the structure of the State in it's role of maintaining inequalities is due.

Different structures and ways of delivering and building health at a community level need to be explored.

The development of "from the community" non-state health structures is significant as they show the organic development of health care that comes from, is constituted of and controlled by the community and has potential to fundamentally change the relationships in society to increase freedom, participation and health.

**204 INCLUSIVE HEALTHCARE WORKPLACES FOR NURSES**

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Romanow calls for a “commitment to social inclusion and Civil Society” as a way of building a wellness model for all Canadians. Social cohesion and inclusion are social determinants influencing the health and wellbeing of individuals and collectives. In Australia, Eva Cox linked social capital with building a truly civil society. Social capital both arises out of, and helps build a sense of social trust, reciprocity and inclusion on which social exchange in healthcare is based. Healthy workplaces are essential for the retention and recruitment of nurses and for health system sustainability. Healthy workplaces are defined as practice settings that maximise the health and wellbeing of nurses, optimal patient outcomes and organisational and system functioning. This study therefore utilised three social capital categories (World Bank 2004) to firstly analyse the extent to which nursing front-line managers (FLM) were integrated in a tertiary hospital in Canada and secondly, used social capital theory to develop interventions enhancing integration and effectiveness. Social capital categories utilized were: structural (networks); cognitive (trust and solidarity); and outputs (collective action, cooperation; communication; social cohesion and inclusion).

STUDY OBJECTIVES: (1) to identify motivators and barriers to inclusion of FLMs; (2) identify and test interventions conducive to health, inclusion and effectiveness of FLMs in healthcare workplaces.

STUDY DESIGN: we conducted taped interviews with FLMs and senior decision-makers. Tapes were transcribed verbatim and Morse and Field's (1995) criteria guided the data analysis: comprehending, synthesizing, theorizing (using the three social capital categories) and recontextualising).

PRINCIPAL FINDINGS: Interventions we propose include: (1) senior decision-makers championing FLMs as organizational change agents who can broker knowledge within and across professional networks/groups; (2) building social capital in organisational networks; (3) explicitly addressing social and power inequities to improve democratic decision-making and diversity; (4) building common understandings to strengthen organizational integrity.

IMPLICATIONS FOR POLICY/PRACTICE: Interventions developed have international utility to strengthen the “virtuous cycle” and integrity of healthcare organisations. Common to senior decision-makers is the responsibility to craft better working conditions that lead to better health of workers and better productivity in healthcare workplaces. Although the focus of this study was to develop social capital theory in health care workplaces and improve the effective integration of FLMs, these interventions also have capacity to strengthen interprofessional practice in health care workplaces.

**Hogan**

Michelle

Tue Sept 12 - 11.00 - 4.00 - Equinox Room (Poster)

Dale St Women's Health Centre - Primary Health Care Services

Australia

14 *PLUS + CONNECTION : WOMEN'S HEALTH THROUGH CREATIVITY*

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This two-hour workshop is an interactive exploration of key themes, processes and outcomes of two major health-through-arts projects within a feminist women's health centre in Adelaide, South Australia.

The art projects are placed in a 21-year history of the Dale St Women's Health Centre, which successfully enlisted Community Cultural Development processes as a means of addressing core health objectives and facilitating the expression of strong and creative voices of marginalised women in the community.

Organisational change including moving the women's health centre to a new facility in 2003 inspired creating a strong community ownership to the new public building, and ensuring the new space reflected the diversity of community women's needs in terms of safety, cultural appropriateness, and the sense of community and domestic place that support women's well being.

The workshop will explore the intersection of community cultural development with feminist women's health in working with over 120 community women in documenting and translating their lived and often complex stories into a Floor Design and Interactive Women's Story wall.

Detailed aspects of project processes will be explored including community consultation and participation where listening is reflected in the extensive nature of documentation and re-engaging opportunities with community women in a context of safety, confidentiality, respect and acknowledgement

Interactive exercises in the workshop will reflect aspects of the design process and highlight how art practitioners and community art makers worked through a model of transposing the spoken word to the visual images

Attention to social and health outcomes for individual women involved, for community groups and the ongoing community connectedness that is facilitated through the presence of the art installations will be outlined.

This workshop will use creative graphics, video and interactive activities to describe the project, map the evaluation process and outcomes and involve participants in examples of the collaborative community art making process that directly impact on individual and community health. Be inspired !!!

**151**     *THE PLAYFORD FOOD ALLIANCE - A PARTNERSHIP FOR FOOD SECURITY*

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**PURPOSE:** This presentation describes the Playford Food Alliance, a project that tackles the issue of food security in a northern area of Adelaide with high levels of disadvantage, known as the "Peachey Belt". . The project used a community development approach that was designed to address the issue of inequitable access to nutritious food and knowledge about nutrition through intersectoral collaboration. The evaluation findings on the effectiveness of collaboration and partnership in addressing inequities in food security are examined

**METHOD:** The external evaluation utilized a number of qualitative methods including interviews, observation and document analysis to assess the way in which intersectoral partnerships were used and how effective they were in addressing food security.

**RESULTS:** Intersectoral collaboration is one of the key means of addressing social and health inequities and the evaluation showed that the partnerships formed in the project fulfilled many of the pre-conditions for successful collaboration. These include: common goals, mutual benefits, trust and effective communications, shared resources and community input. The Playford Food Alliance project management group included representatives from community health, education, housing, welfare, local government, horticulture and retail businesses. There was also a community advisory group with local residents involved. Each member contributed in some way to one or more of the project's strategies and a number developed new services in collaboration with other partners.

**CONCLUSION:** The Playford Food Alliance's community development model and promotion of partnerships led to a number of successful initiatives that are addressing food security and therefore inequity in the Peachey Belt area. These include a peer education program for community people interested in the promotion of nutrition, a fortnightly Farmers market where local producers sell fresh food to the community and a food services directory. All these initiatives arose as a result of collaborations between the project's partners and their success has the potential to be a model for similar projects addressing food insecurity and inequity in similar areas.

78 *RACE/ETHNICITY AND LENGTH OF HOSPITAL STAY FOLLOWING KNEE OR HIP ARTHROPLASTY: AN ANALYSIS OF THE VA NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM DATABASE*

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**BACKGROUND:** Knee/hip osteoarthritis is a leading cause of disability and a threat to quality of life in the elderly. Once conservative management is exhausted, knee/hip total arthroplasty is an effective treatment option for patients with end-stage knee/hip osteoarthritis. However, there are marked racial/ethnic differences in the utilization of this treatment. Compared to white patients, African American patients are more likely to express concerns about the duration of hospital stay after joint arthroplasty. There are limited data on racial/ethnic differences in hospital length of stay after knee or hip arthroplasty. Therefore, we sought to examine race/ethnicity and length of hospital stay following knee or hip arthroplasty using the VA national database. The VA provides a unique model to study health care inequity in the US because it is not confounded by differences in access to care.

**METHODS:** We used the VA National Surgical Quality Improvement Program database to examine the relationship between patient race/ethnicity and hospital length of stay among US veterans who received knee or hip arthroplasty between 1996 and 2000 at 123 VA hospitals nationwide. Race/ethnicity-specific post-surgical length of stay was summarized using Kaplan-Meier plots. Post-surgical length of stay was modeled using a discrete-time proportional odds model, with hospital site as a random effect.

**RESULTS:** We identified 11,739 patients with an index total knee arthroplasty (including 11.3% African-American and 4.7% Hispanic) and 6,524 patients with an index total hip arthroplasty (including 16.9% African American and 3.5% Hispanic) who had post-surgical length of stay information. Mean length of stay following knee arthroplasty was 6.6, 7.6, and 7.1 days for white, African American, and Hispanic patients, respectively. The corresponding means following hip arthroplasty were 7.1, 7.7, and 7.5 days. Following knee arthroplasty, African American and Hispanic patients were more likely than otherwise similar white patients to be discharged on the day of surgery (OR=3.34 and OR=9.38, respectively;  $p \leq 0.001$  for each). Both African American and Hispanic patients were less likely than otherwise comparable white patients to be discharged on any given day after day 3 (OR=0.767 and OR=0.83, respectively;  $p < 0.01$  for each). Following hip arthroplasty, both African American and Hispanic patients were significantly less likely to be discharged on any given day than otherwise comparable white patients (OR=0.78;  $p < 0.01$  and OR=0.83;  $p = 0.04$ , respectively).

**CONCLUSIONS:** Compared to white VA patients, African-American and Hispanic VA patients generally had longer post-operative length of stay following knee or hip total joint arthroplasty.

203 *National Sanitary Objectives. Evaluation of health equity goals (GEGA Panel Presentation)*

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In the year 2000, after a detailed diagnosis of the health situation in the country, the “Health Objectives for the decade 200-2010” were defined. With the aim of prolonging the healthy life span of Chileans and reducing inequities in healthcare, each objective has specific goals and depicts the variety of strategies required to improve health status of the population, integrating, whenever possible, health risk factor interventions, health determinant perspective and reorganization of the healthcare system, in the context of a mayor Health Reform. These four basic objectives are:

- 1.To maintain and improve sanitary achievements.
- 2.To face challenges arising from aging of the population and societal changes.
- 3.To reduce health inequities.
- 4.To provide services according the population expectative.

The Chilean Health Equity Initiative, along with the Ministry of Health, carried out a study to evaluate the progress in fulfilling the third objective, particularly in Infant Mortality and Life Expectancy by level of schooling trough 1998-2003.

**METHOD:** Analyzing Live Births and Deaths 1998 to 2003 databases; Census 2002 population estimates and CASEN Surveys\*, general life expectancy and mortality rates were calculated by sex and educational attainment, determining the gaps or relative risks between extreme educational groups. A contextual look to health determinants like education, income, gender and ethnic groups' situation was also included to explain results.

**RESULTS:** Social determinants like education and gender perspective keep their positive trends at the national level; however, there are still gaps to close in income distribution and situation of ethnic groups.

Infant mortality decreased from 9.9 in 1998-2000 to 8.2 children per thousand live births in 2001-2003. However, differential mortality between children of mothers from extreme educational groups increased by 15%. These mothers with very low level of education, most likely belonging to ethnic groups and/or residing in areas with very low autonomous income averages, should be targeted to improve their situation.

In regards to life expectancy, Chilean population, already in a good situation, also improved in the study period. Nevertheless, from an equity point of view, men in the lowest educational level showed a slight decrease in life expectancy at 20 years old. In women, overall increase observed is mainly due to increase in higher education groups.

**CONCLUSION:** Despite improvements, there is still a challenge for the authorities, and for society as a whole, to decrease and eradicate the gaps in health equity that still persist in our population. \* CASEN surveys: serial national survey to evaluate social policies.

64 *Gender disparity in child health in India: Does place matter?*

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The strong preference for sons over daughters and resulting discrimination against daughters in India is well known, though the preference is not uniformly observed across different regions of the country. India exhibits wide variations in the degree of sons' preference, with strong son preference found in northern India than in the south.

Despite exhibiting great disparity in son preference in India, detailed explorations into the extent, pattern and nature of gender disparity in various possible parameters of discrimination has not been undertaken. Importantly, the clustered nature of health outcomes (due to neighbourhood effects) or the nested nature of populations- i.e. areas (such as districts or states) as aggregates of households, and households as aggregates of individuals and various processes within them is overlooked. Most research of this type has been concentrated in comparing a few states of north and south India and mainly documented gender differentials in child mortality.

Using a multilevel framework, the aim of this paper is to document and examine regional patterns of gender disparities in immunization and nutrition (defined as weight-for-age), using phase II of National Family and Health Survey (NFHS-2). The focus is on the following questions: First, are boys more or less likely to have complete vaccination coverage than girls? Second, are girls more or less likely to be malnourished than boys? Are there significant differences across different states in gender disparity in complete immunization and nutrition after accounting for individual and family variables?

The findings of this paper challenge the growing body of literature which suggests that a greater gender disparity in health is found in north than in South India and that girls in South Asia are discriminated against in the provision of health care but are not neglected in nutritional allocations. We found that on average, girls less likely to be immunized in India but the gender disparity in immunization does not seem to vary across states. Regardless of state of residence, girls are equally disadvantaged in all the states. Gender disadvantage in the risk of being not immunized persists even after controlling for a range of covariates. However, we found some evidence that there is variation in gender-difference across states in the risk of being stunted (weight-for-age).



**28**     *Reorienting of Health Services to improve population health and reduce health inequity*

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There is widespread recognition that substantial reorientation of health services is needed in industrialised countries to make health services more effective in improving population health and reduce health inequity through health services incorporating health promotion into core business and becoming health promoting health services. This emphasis on health promotion as an extension to clinical and curative care to sick or injured individuals is fuelled by the fact that health systems in industrialised countries are unsustainable, and need to better utilise existing resources to be part of a concerted move to improve population health and reduce health inequities.

“Settings” for health promotion was one of the Health For All policy targets for the WHO, whereby they advocated that all settings of social life and activity such as the city, school, workplace, hospitals, neighbourhood and home, should provide greater opportunities for promoting health (WHO 1981). The goal of a settings-based approach to health promotion is to create a supportive environment for “health”. There has been a substantial amount of effort over the past 15 plus years in Europe to developing hospitals as settings for health promotion, with some work also being conducted in Scotland and Australia looking at the broader concept of health promoting health services.

A new framework titled Health Promoting Health Services Reorientation Framework will be used as a basis for this paper to present a new way of conceptualising the reorientation of health services to become more health promoting. The Framework is evidence based and has been developed based on many years of experience that the author has had in reorienting health services and advising others; findings from research and evaluation (Johnson 1998; Burke 2002; Skinner 2002; Martin 2004; McLean, Feather et al. 2005); and critical reflection about what components appear to work well, and what components are missing when things don't work well in different approaches to reorienting health services. This paper will advocate for a broader view of organizational development which is value driven based on a Primary Health Care approach, and incorporates the relationship the health service has with the external environment and highlights the importance of leadership, mission and strategic direction, culture, policies and clinical and management processes of health services to effect change. This approach to reorientation is aimed at creating transformational and transactional change in health services.

**24 GENDER INEQUALITY & HIV/AIDS: DOUBLE JEOPARDY OF WOMEN**

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**BACKGROUND:** Current statistics indicate that 6.1 million people in South Asia are infected with Human Immunodeficiency Virus (HIV). HIV is an extraordinary kind of crisis. It requires an exceptional response that remains flexible, creative and vigilant on the one hand and on the other hand those who are affected needs a multi dimensional approach to their lives. Now HIV infection in Nepal has a female face because of it growing fastest in this subpopulation. How Gender & HIV/AIDS make women jeopardized? Gender is a crucial element in health inequalities in developing countries. Gender can be conceptualized as a powerful social determinant of health, which interacts, with other determinants such as age, family structure, income, education and social support and a variety of behavioural determinants. In a patriarchal system, men dominate women and exercise control over their lives including their sexuality and reproductive choices. Nepalese women's vulnerability for HIV is further fragmented by a combination of factors such as biological, social- class, caste, urban/rural location, sexual orientation, culture-, economic and legal etc. These factors have an impact on women's access to services, resources and information.

**OBJECTIVES:** A study was conducted with PLWHA women during 2003-2005. To examine the complexity of HIV/AIDS and to learn more about the specific problems faced by women living with HIV - how the concept of gender & HIV/AIDS make their life vulnerable.

**METHODS:** Case Studies and Informal Interviews with HIV infected women. Data was analysed with EPI info program.

**RESULTS & CONCLUSIONS:** Case studies and interviews with women from the study illustrate that low status in family, sexual violence, economic and social problems such as poverty, lack of education are some of the primary reasons to get infection. Cultural orientation inhibits them to talk about sex to their partners, which results in infectious status. In the middle-aged women, after sterilization they do not practice regular use of condoms, because they think it is primarily for family planning. Among the newly-married women they know their status only at time of pregnancy, which results in psychological trauma and other related aspects. Most of them are widows and they know their sero status at a later stage of their partner's HIV infected life. After the death of their partner, some of them are being expelled from their home and undergo various violations of human rights.

**Key words-** Gender, HIV/AIDS, Women, Vulnerability, Rights

**88**      *Inequalities in Mental Health care and treatment for indigenous people - A Maori Perspective.*

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From a Maori perspective there are inequalities in mental health care and treatment in accessing cultural expertise and practice of wellbeing, with a need to recognize cultural psychological and spiritual perspectives working to achieve wellbeing.

Some of these that we have acknowledged are:

- Inequalities of spiritual issues/illness verses scientific evidence based outcomes defining the parallel.
- Diagnosis – giving a wrong or incorrect clinical diagnosis for a spiritual issue/illness.
- Traditional healing – accessibility and safety of cultural practitioners and healing methods giving indigenous people the option or choice of using cultural assessment / .practice along side of conventional medicines, methods and practice.
- Social stigma attached to Maori traditional healing from the lack of awareness and understanding with the need of education on these aspects of health care and treatment.
- The practice of and acceptance of Maori best practice models and assessments to assist, treat and deliver quality health care.
- Quality cultural education to all clinicians, doctors and psychiatrists on an awareness and understanding of Maori terminology and practice, with appropriate Maori models of health care, methodology and practice.

A case study presentation will highlight the methods of which to assess the cause, how to treat the cause not the symptom, identify the cause if linked to spiritual aspects not clinical diagnosed illness and define the source linked to the spiritual / medical (physical or internal) or psychological issues affecting the wellbeing.

Equity for Maori people's mental health care begins with;

- Quality cultural education programmes that deliver to all mental health clinicians an awareness and understanding of Maori psychology perspectives, methods of traditional healing and terminologies parallel to western.
- Recognition from western medical practice to align traditional healing with conventional medicines and methods of practice.
- Acknowledge and implement within western mental health systems Maori best practice models and cultural assessments, to work alongside of conventional medicines and practice aligning cultural terminologies of psychology with western.
- Creating Maori workforce development by delivering training programmes for Maori with expertise in traditional healing methods of practice, to work along side of western clinicians from a psychological perspective to assist mental wellbeing.
- Implement quality policies on safety, access and practice for cultural practitioners to work parallel with western mental health systems to assess, treat, care and assist recovery of mentally unwell Maori within mainstream services.

58 *ABORIGINAL WOMEN'S HEALTH - COLLABORATION IN ACTION*

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Australian Aboriginal women have reported mixed experiences from the health system. There are examples of good practice in urban health services, but there are also many instances of racist attitudes, restricted access to mainstream services, short-term programs with spasmodic funding and culturally unsafe care. Meanwhile, Aboriginal women's health status remains unacceptably low due to a complex mix of colonisation, and social, economic and environmental determinants of health.

Changes to the ways health and wider services work with Aboriginal people are urgently needed. It is unacceptable that Aboriginal people continue to experience poor health outcomes while living in an industrialised country with an internationally recognised health system. Recently the South Australian Government has recommitted to improving Aboriginal health status through increased comprehensive primary health care and multi agency collaboration. It has endorsed the national Cultural Respect document. Policies have been created, but have not yet impacted on practice or positively effected health outcomes. The question remains for practitioners and researchers- how can sustainable and realistic changes be put it into practice at a local level?

This paper is a work in progress that discusses what we have learnt through developing a collaborative approach between an Anglo community health nurse, local Aboriginal women and a community health campus in response to Aboriginal women's concerns that neither Aboriginal nor non-Aboriginal health services were adequately equipped to meet their health needs.

Participatory action research was chosen as the most appropriate way to address the considerable tensions that exist between local Aboriginal women's and community needs and expectations, health service structures and academic research requirements. A community-based model has been developed with Aboriginal women positioned as integral co-researchers in all phases of the research planning and development. This required the development of trust and understanding between the researcher, Aboriginal women and communities involved. Cultural permission for the research was given and with it came an expectation of positive change. The encouragement and support of disenfranchised Aboriginal women to re-engage with the health system, and vice versa, has brought with it many complex considerations regarding personal and cultural safety for all involved.

In this session we discuss how we have grappled with recognising and honouring such diverse forms as knowledge as lived experiences, urban Aboriginal culture, Western medicine, academic research and women's ways of knowing. We have learnt how we can all work together to improve Aboriginal women's health. We share our learning with you.

228 *A 'hypothetical' complaint to the United Nations Committee on Economic, Social and Cultural Rights alleging violation of the right to health of Aboriginal and Torres Strait Islander peoples*

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The following paper presents a 'hypothetical' complaint to the United Nations Committee on Economic, Social and Cultural Rights (the Committee) in reference to the Draft Optional Protocol (DOP) to the International Covenant on Economic, Social and Cultural Rights (ICESCR). The complaint alleges that the Australian government is in prima facie and 'actual' violation of the right to health of Aboriginal and Torres Strait Islander peoples. It focuses on the Government's compliance with two "core obligations" described by the Committee in its General Comment No.14 on the right to the highest attainable standard of health (2000). These are the obligations to ensure non-discriminatory access to, and equitable distribution of, "health facilities, goods and services". While a complaint alleging violations of these rights from the entire Australian Indigenous community might be too broad for the Committee, the facts presented could form the basis for complaints from smaller groups or individuals with respect to particular services. This complaint is hypothetical because unlike most of the major UN human rights treaties, ICESCR does not at this stage, have a 'complaints' procedure. The Australian Government has however been legally bound by the ICESCR since it ratified the treaty on 10 March 1976. The DOP developed by CESCR in 1997 provides a valuable basis for the development of a 'complaints' procedure to ICESCR. The development of such a procedure is currently under consideration by a United Nations working group.

The hypothetical complaint will consider whether domestic remedies have been exhausted and apply the criteria for equitable and non-discriminatory access to health care set out in the Committee's General Comment No.14 on the right to health. This is in terms of availability (actual existence of services), accessibility (physical, economic and informational and non-discrimination), acceptability (including cultural appropriateness) and quality. In seeking to show that discrimination is occurring the complaint also makes reference to health indicators used by the Committee, including health status, policy and expenditure indicators. While these factors point to prima facie violation in terms of what could be called "actual" violation, the complaint will consider whether the government has made every effort as a matter of the highest priority using all available resources to meet its obligations under the Covenant. The conclusion in the complaint in this respect is that the government is "unwilling" rather than "unable" to fulfill its obligations and therefore in violation of its obligations.

**236**     *Promoting Equity through Health Literacy*

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Research demonstrates that outcomes in health care are affected by the consumer's ability to "access, understand, evaluate and communicate information to engage with the demands of different health contexts to promote good health across the life-span" (British Columbia Health Literacy Measurement Research Team, Personal Communication, Irving Rootman, April 2, 2006). This ability to engage meaningfully with health information is termed health literacy. Health care systems, battered by decreasing budgets and overwhelming demands, are increasingly devolving the responsibility for accessing, interpreting, and using complex health information to the individual, in spite of the recognition that this is well beyond the capacity of most citizens (Institute of Medicine [IOM], 2004). It is widely acknowledged in both literacy and health promotion circles that over forty percent of Canadian adults have literacy difficulties leading to increased health challenges, with low literacy being most prevalent in Atlantic Canada (Statistics Canada, 2005). Among marginalized populations, such as indigenous and immigrant populations, both broad and specific equity issues become more urgent, as the high rates of chronic illness and inadequate literacy intersect to exacerbate negative health outcomes (Statistics Canada, 2005).

This research project focuses on a systematic analysis of structures and resources affecting health literacy policy and practice in Nova Scotia, Canada. These structures, resources, delivery practices, and policies all converge to influence not only the access, but uptake and utilization of health information. By establishing a baseline understanding of the basic structural integrity of the system, the range of services, providers, and resources available, and the nature of current formal and informal practices, a conceptual map can be developed to illustrate the scope of health literacy initiatives in Nova Scotia. Through this process of inquiry, researchers will develop an understanding of where strengths and gaps exist in current health structures, enabling a proactive approach to policy development which will support positive action to equity issues and promote positive health outcomes for all Nova Scotians. Partnerships with key stakeholders in the Departments of Health, Health Promotion, and Education, serve to enable access to relevant stakeholders, policy and delivery documents, and practitioners. Further stakeholders will be identified over the course of the project and may include additional government service departments, advocacy groups, and others.

127 *Equity Analysis by Community – a pathways for equity in health and health care (GEGA Panel Presentation)*

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If Equity-concerns are to become meaningful to the lives of the vulnerable populations, they must be reflected in health policies and programmes of a country. In most developing countries, policies and programmes are not guided by equity concerns (barring some exceptions – Sri Lanka, Cota Rica, to name a few). Market ideology is rolling back the responsibilities of the State, specially in the social sector. Deeper rooted class prejudices bolster neglect of the poor and marginalized, and protect the powerful. Resources are distributed not with a sense of 'public good', as well reflected in the contradiction of becoming a nuclear power, while poverty increases, and inequities expand. (As in the case of Pakistan. With decisions on polices and programmes secure in the hands of the power elite, community involvement becomes an imperative.

Through an exploratory work to introduce the benchmarks of fairness in health care (n.Daniels 2000) a pathway was found that enables community groups to analyse inequities, and priorities the disparities they would like to see reduced. Analysis was done in 21 villages, in separate groups of men and women, using PRA techniques (participatory reflection and analysis). Participants made an illness matrix, then a social map showing all the households of the village. Households where the illnesses took place in the previous year were marked. Community groups then discussed the differences between the two types of households. The differences were then priorities, and community groups asked to nominate their representatives for discussion and short listing of priorities in their Union council (Smallest administrative unit, as part of the district government).

Priority setting workshop, followed by district level discussion on the findings in order to influence district development plan was organized. Folk music was used to highlight the issues of justice in health and health care. (local folk music carries the theme of justice) This is work in progress, and so far has yielded the viability of mobilizing communities for equity in health. How the communities address the issue of power relations within their social realities is a challenge that is likely to be faced and strategies are likely to be identified.

Pathway to community analyzing their social realities for inequities has been found; training community groups in evidence based advocacy is the second part of the pathway to equity in health and health care at the district level.

**109 GROUP PREMIUMS IN MICRO HEALTH INSURANCE EXPERIENCES FROM TANZANIA.**

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**OBJECTIVE:**

The main objective was to assess how group premium can help poor people prepay for health care services

**METHODS:**

A comparative approach was adopted to study four groups of informal economy operators (cobblers, welders, carpenters, small scale market retailers) focusing on a method of prepayment which could help them receive health care services. Two groups with a total of 714 operators was organized to prepay for health care services through a group premium, while the other two groups with a total of 702 operators were not organized to prepay through this approach. They prepaid through individual premium each operator paying by her or himself. Data on the two groups which lived in the same city was collected through a questionnaire and focus group discussions. Data collected was focused on health problems, health seeking behaviour and payment for health care services. Training of both groups on health care financing and types of premiums was done.

**RESULTS:**

Data collected showed that the four groups were similar in many respects. These similarities included levels of education, housing, and social services such as water supplies, health problems, family size and health seeking behaviour. At the end of a period of one year 76% of the members from the two groups who chose group premium payment were still members of the prepayment health scheme and were receiving health care. For the two groups which opted for individual premium payment only 15% of their members were still receiving health care services at the end of twelve months.

**CONCLUSION:**

Group premium is a useful tool in improving accessibility to health care services in the poorer segments of the population especially the informal economy operators

**Key words.**

Prepayment for Health Care, Health Microfinance Insurance Scheme, Group Premiums.



183     *INEQUITY IN INDONESIAN  
HEALTH SOCIAL SAFETY NET PROGRAM*

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The first goal of the Millennium Development Goals is to eradicate extreme poverty and hunger by halve in 2015. Poverty affect the health of the people, and the poor is vulnerable to diseases due to poor nutrition, shortage of proper knowledge and behavior for healthy life style, poor environmental condition and poor access to health care. Social Safety Net (SSN) Program in the health sector has been implemented since the economic and monetary crisis hit Indonesia in 1998, to assist the poor getting adequate access of health care. It is known that the health status of the poor is worse compared with the rich; the Infant Mortality Rate discrepancy was 53 per 1,000 live births vs 24 per 1,000 live births. A recent evaluation is carried out to assess the horizontal equity of the distribution of the program. The recent data from the Statistics Indonesia (BPS 2004) shows that 16.7 % of the Indonesian are considered as poor and the coverage of the SSN program only 8.6%. Using the 2004 National Socioeconomic Survey data, 266,000 households were divided into five groups (quintile) based on household expenditures. The expenditure of the poor for health care was only 2.6 % from total expenditures (Rp. 9,432) in one month compared with the rich that is 4.1 % from total expenditures (Rp. 77,216). The results show that in 2004 the Health Card of the SSN program only covered 13.6 % of the poorest group (first quintile) in Indonesia. Coverage of the Health Card for the Poor varied from 3 % in Maluku Province to 36.5 % in Nanggroe Aceh Darussalam Province. About 26.5 % of the rich group (fourth & fifth quintile) also received the Health Card. Utilization of the health care services by the poor (first quintile) compared with the rich (fifth quintile) in public hospitals also differed, for out-patient services: 3.8 % vs 7.9 % and for in-patient services: 41.1 % vs 45.0 % . Utilization of the General Practitioners: 24.0 % vs 36.4 % . Various local studies show that the other important barrier to the utilization is the transport cost to visit the health facilities. It can be concluded that the Pro Poor Strategy and the Social Safety Net program in the health sector in Indonesia need to be improved to reduce the horizontal inequity, by ensuring adequate and equitable access to needed health services; so that people in equal need of care are treated equally.

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**173**     *Women's Self-Help Groups and Role of Caste and Class in Equitable Health Access*

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**BACKGROUND:**

Self-Help Groups (SHGs) are small voluntary associations of people from the same socio-economic background with a purpose of solving their common problems through self-help and mutual help. It is assumed that the current approach of empowerment through SHG will help to remove social exclusion of poor women. It is also assumed that women's self-help groups will play a larger role in its contribution towards improving women's health and providing equitable health access beyond caste and class distinction as well as for achieving 'Millennium Development Goals' in developing countries. These assumptions are largely based on the global neo-liberal agenda which suggests that the State should withdraw from social provisioning. The paper reviews scope and limitations of self-help groups in improving women's health and providing equitable health access focusing on empirical work undertaken in one of the Indian States. This paper emphasizes the role of caste and class in access to health services and explores the extent to which SHGs can be involved in attaining better health for women and children.

**METHODS:**

The paper is based on field surveys, interviews and select case studies on sample of two hundred women Self-help group members in Patna district of Bihar which also happens to be the poorest state of the country. The findings are based on qualitative and quantitative analysis which explore critically the linkages between SHGs, role of class and caste and access to health services.

**RESULTS:**

The result shows that major activities of SHGs are more focused on saving and credit activities than on empowering women and facilitating access to health services. Although SHGs were expected to play a significant role in women health and access to better health services, caste and class, health belief and perception came out as primary hindrance in access to better health services. The findings also show that without changing the barriers of caste and class based discrimination, it is not possible to achieve inclusion of marginalized (especially women and poor) in the society and to provide better health access and life.

**CONCLUSIONS:**

It is concluded that solutions such as self-help which emanate from the international policy circles do not capture the contextual issues leading to instrumentalized approaches and sub-optimal results. The approach has its own limitation and without addressing the local contextual realities like caste and class, it is not possible to provide equitable health services to poor and marginalized.

**118**     *MEASURING EQUITY IN COMMUNITY HEALTH- RESEARCH TO PRACTICE.*

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**PURPOSE:** to discuss the development of a tool to measure equity in small scale, local community health programs

**METHOD:** A systematic review of community health evaluations in Adelaide was conducted in 2004 by the South Australian Community Health Research Unit (SACHRU) and a team of reviewers from Community Health. One of the review questions was how well evaluation reports had dealt with the question of equity in the program delivery. The review found that while equity was addressed briefly in some reports, in many cases it was implied rather than systematically analysed. The review and subsequent focus groups with community health staff identified a number of barriers to evaluating equity including lack of time and resources to undertake evaluation, difficulties in defining and measuring equity and a concern about the ability of evaluation to accurately measure outcomes and influence practice.

**RESULTS:** In response to these issues, SACHRU has developed an equity tool designed for small scale, local community health programs that makes equity issues explicit in their planning, delivery and evaluation. It is intended that widespread use of this tool will allow future systematic review of the evaluation of equity in community health.

**CONCLUSION:** This tool is an attempt to move toward a more explicit and consistent equity focus in community health planning and evaluation. It also seeks to take the research evidence gathered by Community Health and SACHRU and use it to influence practice in addressing equity

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**184**     *MEASUREMENT AND DECOMPOSITION OF SOCIOECONOMIC INEQUALITY IN HEALTH AND MENTAL HEALTH IN TAIWAN*

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**OBJECTIVES:** This paper aims to measure and decompose socio-economic inequality in health and mental health of Taiwan residents by using concentration indices and decomposition techniques. Using a representative national survey in Taiwan, this is the first attempt to quantify the level and the causes of inequalities in health and mental health

**METHODS:** The data from the 2001 Taiwanese National Health Interview Survey incorporated a multi-stage systematic sampling. 18,142 subjects aged 12 and above provided effective answers to the questions on general and mental health domain of SF-36 Taiwan version. We measured inequality in general and mental health using concentration indices. Decomposition techniques were used to decompose inequalities into their socio-economic causes. The interval regression approach was involved to map the empirical distribution function of ordinal household income, while measuring income-related health and mental health inequality.

**RESULTS:**

Significant inequalities in health favouring the higher income groups emerge in both general and mental health, but particularly high for residents in remote areas. The decomposition analysis shows that in remote areas income itself accounts for a significant and sizeable contribution (43.1%~63.1%) of general and mental health inequality. By contrast, in non-remote the largest contributions inequality comes from inequality in education (29.6%) to general health inequality and from being employment (30.3%) to mental health inequality. Apart from these factors, age, suffering chronic diseases and lifestyles are also important contributors to both general and mental health. After controlling for demographic inequality, in non-remote areas the avoidable income-related health inequalities are 0.0116 and 0.0072 to general and mental health respectively, while in remote areas they are 0.0255 and 0.0136.

**CONCLUSION:** Although in Taiwan socioeconomic health and mental health were distributed fairly equally, the evidence of pro-rich inequality is obvious. Our results have implications for the design of appropriate social and health policies targeting health within different vulnerable groups.

**Key words:** health, mental health, inequality, decomposition, interval regression, Taiwan

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**46 HEALTH EQUITY AFTER UNIVERSAL HEALTH CARE COVERAGE IN THAILAND: PERSPECTIVES FROM PROVINCIAL HEALTH OFFICERS**

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**OBJECTIVE:** To solicit the perspectives of health managers on the priority equity issues and degree of equity achievements after an implementation of the universal health care coverage (UC) in Thailand.

**METHOD:** Senior officers in 75 provincial health offices (PHO) were surveyed using 1 (least)-to-5 (most) rating, self administered questionnaires, during December 2005. Respondents ranked the inequity issues with respect to geographic, demographic, and socio-economic determinants, as well as insurance coverage based on inequity levels and feasibility to minimize the inequity gaps; then rated the levels of equity achievement after the UC policy.

**RESULTS:** Of 96 returned questionnaires, inequity across three public insurance schemes was rated by 21% of respondents as high priority on its importance (mean score  $\pm$  SD 3.38 + 1.02) and on feasibility to solve (score 3.46 + 0.94). Other determinants showed an inverse relationship between the inequity level and feasibility to minimize it. Inequity due to economic status was rated by 38.6% of the respondents the highest score (3.98 + 0.98) on the importance criterion but the lowest score (2.60 + 1.20) on the feasibility. The second most important determinant (score 3.73 + 1.03), urban-rural differential, was perceived by 29.7% of the respondents with the second lowest feasibility to be resolved, score 2.71 + 1.16. Health care utilization and direct health payment are the two dimensions viewed as the greatest impact of the UC policy with the maximum average increases in the scores by 1.07 (SD=0.89) and 1.02 (SD=1.34), respectively. More than one-third (35.8%) of the respondents rated the utilization a relatively low degree of equity before UC and a medium-high degree after UC, whereas 2.1% responded in the opposite direction. For health payment, 37.6% perceived an improvement in the equity after UC, whereas 5.4% saw the deterioration. Health care responsiveness was deemed the smallest impact of UC (mean change=0.29, SD=1.11).

**CONCLUSION:** The PHO senior officers viewed the economic and urban-rural differentials as the most important determinants of health inequity. This warrants immediate attention, as both determinants were unlikely to be resolved easily. The health inequity across three public insurance schemes was perceived as high priority but also feasible to minimize the gap, through harmonization across these insurance schemes. The equity impact of UC was achieved in term of utilization and health payment.

## 107 HOW IS ABORIGINAL HEALTH POLICY IMPLEMENTED?

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There have been many policy initiatives by governments and the health sector that are intended to redress differences in health status and life expectancy between Aboriginal and non-Aboriginal Australians, but with few exceptions there has been limited progress. The Northern Territory Department of Health and Community Services regard the health of the Aboriginal population as a priority. Policy development has improved and is now closer to meeting the standards of good practice, but much less attention has been given to implementation. In fact, there is a perception in the literature and among public health practitioners that many policies are not implemented and that hence, no improvements in health are achieved. In other words, even when problems are identified, and culturally safe policies are developed, there is failure at the implementation stage. However it is possible that failed implementation is an outcome but not a diagnosis of where the policy to action continuum failed.

Qualitative research was conducted to: explain how health policy is intended to contribute to eliminating persistent inequitable levels of Aboriginal mortality and morbidity in Australia; and to identify actions to improve health sector capacity to implement policy intended to improve Aboriginal health. The research involved a case study of the implementation of the Northern Territory Preventable Chronic Disease Strategy.

In addition to a comprehensive review of the literature, 35 in-depth interviews and analysis of relevant documentation have been undertaken. Interviewees included service providers (Aboriginal health workers, nurses and doctors) and bureaucrats (policy directors and officers), across urban and remote areas of the Northern Territory.

Initial results reveal that:

- policy evolves as it is implemented (as opposed to emerging complete and ready for adoption);
- implementation occurs through a process of collective negotiation. Professional backgrounds, decision makers' values and priorities; structures; historical factors; clarity of policy objectives; and participation of service providers and communities all influence which aspects of a policy are implemented;
- on occasion there are disconnects between service providers and bureaucrats: created by conflicting incentives and unawareness of pressures and limitations of others' roles; and
- the degree to which responsibility for Aboriginal health is shared among: individuals, families, communities, service providers and governments, is contested. Blurred definitions may act as a barrier to running accessible and efficient health services.

One interpretation of these results is there is a need for structures to support equitable participation of service providers, communities, bureaucrats and other stakeholders throughout the policy process, not just while the policy is being developed.

**226 EQUITY, POLICY AND CHILDREN'S PHYSICAL ACTIVITY**

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We aim to provide fine-grained, contextual and experiential information about how children experience and understand social and geographical environments in relation to their physical activity choices. . We used a qualitative approach, informed by the interpretive paradigm, the 'new sociology of childhood' and the 'critical social geographies of childhood.' We sampled over 400 children, 3 to 13 years, from schools and pre-schools in metropolitan, rural and remote South Australia because patterns of physical activity and overweight in children vary by class and area: including between metropolitan and rural areas and within rural areas. Qualitative techniques were focus groups, drawing/mapping and photovoice. We collected data in schools over two days, returned for a day to conduct workshops with children and their photographs, then returned for feedback and to discuss emerging results with children, parents and teachers. In focus groups we asked what their area was like for a child, places they were allowed to go and any boundaries on their movements imposed by their families. Maps showed how they used and perceived distance and photovoice showed why places were important. Many rural children used more space around homes and in multiple neighbourhoods. Closer analysis showed use of space needed an elaborate system of school buses, sporting and social clubs and adults (predominantly parents) devoting time and logistics to transport children. This in turn is related to public infrastructure and private wealth, control over life and social capital building blocks of trust and reciprocity. Metropolitan children reported smaller, stricter boundaries, constructed from natural and built environmental features and notions of safety and supervision. They were not as happy as rural children about their boundaries. Metropolitan children were more sensitive to danger from motor vehicles and crime. We illustrate pathways between physical activity and area level characteristics sensitive to social class: such as safer co-existence between cars and children and areas with lower fear of crime - both of which are influenced by social class expressed in urban design. Recent attempts to increase physical activity and reduce overweight in children demonstrate little understanding of the sociology of children or of children as active social agents. Our work aims to influence public policy by using children's experiences to show specific pathways whereby physical activity is directly influenced by universal policies to improve transport, allow children and motor vehicles to co-exist more safely, reduce fear of and exposure to crime and build social capital.

**177 RISK AND PREVENTION: PUBLIC HEALTH CARE PROVISION**

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**OBJECTIVES:** The Argentine Health Care System is financed by three highly heterogeneous subsectors not only among them but also within their own organizations: Public, Private and Social Insurance. Institutional fragmentation triggers a net of actions and incentives that reduces the chances of a coordinated health care model with consequences on the efficiency of resources allocation and on the levels of equity on coverage reached. The aim of the research is to demonstrate that the current model promotes demand inducement, generating financial and epidemiological risk shifts against the public sector.

**METHODS:** The methodology, using descriptive statistics and regression analysis, includes comparisons between types of interventions (preventive and curative) by characteristics of the provider and by income quintiles. The document estimates, on one hand, consumption patterns for health services and, public sector's provision priorities, based on the 2003 National Household Survey on Health Utilization and Expenditures.

**RESULTS:** The lack of incentives for promote health care behavior is shown by the survey analysis is: Not only average out of pocket expenditures in health controls is low, but also it represents a bigger share of expenditures for those who need them the most: poor population groups.

**CONCLUSIONS:** Formal coverage that not stimulates preventive care, concluding that capitated monetary payments do not provide enough incentives to change sanitary patterns. Also the study shows adverse selection against public providers, where the higher share of inpatient care for low income groups is found.



**176 DEMAND NEEDS AND SUBSIDIES: MEDICINES IN ARGENTINA**

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**OBJECTIVES:** Between 2001 and 2002, as a consequence of the Argentinean economic crisis, the existent gap between potential and effective demand for pharmaceutical products increased, especially in low income households. As a result, the Ministry of Health launched the Remediar Program, consisting in the public provision of medicines among houses under the poverty line and without formal health coverage. By implementing a subsidy for pharmaceutical products, families can substitute their own purchases by free medicaments, shifting their incomes to alternative uses. Considering that Remediar acts as an indirectly subsidy for the demand of medicines through primary health care posts (CAPS), the main propose is to know the ability of the Program to reduce the gap between potential and effective demands under the poverty line, as well as its effects over welfare in terms of generated savings.

**METHODS:** By using two Household Surveys on Expenses and Utilization at the CAPS level during 2003 and 2004, designed for this research, the paper develops a probit model, estimating the probability of accessing to free prescriptions, as a function of household incomes and socioeconomic characteristics, formal health insurance coverage levels, and the participation of each CAP into the Program. The results were compared to the data provided by the National Household Survey of Expenses and Utilization in Health developed by the Ministry of Health in 2003.

**RESULTS:** Estimations suggest a potential redistributive effect due to the Program, by improving equity on expenditures on pharmaceuticals, which may imply a reduction of the Gini coefficient from 0.11 to 0.08. In addition, population under the first and second income quintile might reach saving of their expenses in drugs of 22.5 and 6.7 per cent, respectively.

**CONCLUSIONS:** The paper shows the effectiveness of the Remediar in increasing the access to medicines of patients at the lowest income quintiles.

**175 SOCIAL PROTECTION IN HEALTH CARE IN ARGENTINA**

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**OBJECTIVE:** Health care systems in developing countries traditionally fail in providing coverage to the poor. Lack of financial resources and weak regulatory institutions do not allow reducing the existent equity gaps associate to income. In the case of Latin America, the countries have developed social insurance institutions in parallel to the public sector in order to improve formal coverage, increase collection of funds and avoiding families' financial limitations in receiving health care. The goal of the study is to identify, in the context of the Argentinean health care system, the mechanisms of social protection (market insurance, self insurance and self protection) measured by population quintiles, and to establish their effectiveness in relieving eventual financial shocks. These shocks are associated with the presence of health care expenditures by type (ambulatory, outpatient care and pharmaceuticals) that eventually increase the probability of falling below the poverty line.

**METHODS:** The comparative analysis is based on data originated in three household surveys (1997, 2002 and 2003), complemented with information related to socio-demographic characteristics and the organization of the national social health insurance system.

**RESULTS:** The presence of different mechanisms of social protection is not related with the individual's ability to choose among systems, but with the family income. Income defines the access to formal social insurance mechanisms and the possibility of contracting private market insurance plans. The presence of self-insurance (savings) and self-protection (measured in terms of expenditures in sport activities) is strongly related with income. Results also show the lack of ability of market insurance schemes to control out-of-pocket expenditures, mainly triggered by induced demand in geographical areas with strong supply of health care providers. Comparisons before and after the macroeconomic crisis that followed the 2002 devaluation show the reduction of formal health coverage, as well as the limitations of alternative social protection mechanisms. In all cases, the public sector, as provider of last resort, was in charge of filling the gap, especially in lower income groups and relative poorer regions of the country.

**CONCLUSIONS:** More research is need for the development of effective regulatory and monitoring structures in three areas: (1) operation of health markets and relationship among supply structure and necessities; (2) definition of basic packages by region and health care profile and (3) implementation of parameters and indicators to follow up the system and provide user's information.

**208** *Canadian Aboriginal Children Relocated For Treatment*

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**RATIONALE:** Bridging the gap between the health status of Aboriginal children and youth and the general Canadian population has recently been identified as a national priority. A paediatric referral network currently relocates Aboriginal children and youth from remote, isolated and under-serviced communities along the west coast of James Bay in Ontario to the Southeastern Ontario Health Sciences Centre in Kingston (1500 km away) for specialized investigations and treatment. Research is limited on the availability, accessibility and appropriateness of this paediatric referral network.

**OBJECTIVES:** The objectives of this study were to determine the reasons for referral of these Aboriginal children and youth to Kingston; to investigate whether these health problems could have been prevented; to determine the strengths and limitations of the tertiary care provided; and to identify any special considerations that could provide more culturally appropriate care for the children, youth and their families.

**METHODS:** A chart review was conducted of all Aboriginal children and youth admitted to the Southeastern Ontario Health Sciences Centre in 2005. This review was based on a questionnaire developed with input and ethics approval from Weeneebayko General Hospital in the James Bay area. The adequacy and appropriateness of resources available in Kingston for the referred patients and their accompanying relatives were assessed. This was accomplished by making observations on the cultural sensitivity of the inpatient and outpatient facilities, and by interviewing health care providers, Weeneebayko Patient Services personnel (who organize transportation, accommodation, and translation), and Child Life.

**RESULTS:** Reasons for referral included injuries, neonatal complications, infectious diseases, surgeries, psychiatric problems, as well as inpatient and outpatient specialized investigations and procedures. Strengths of the referral system included the collaboration of physicians with Weeneebayko Patient Services to consolidate patient appointments and their travel to northern clinics to facilitate patient follow-up. Limitations of the system included weather impeding patient transportation and the impact of separation from family on the patient and primary caregiver.

**CONCLUSION:** Both strengths and limitations exist in the current culturally sensitive health care referral system. One suggestion for improvement involves the effective use of videoconferencing for both medical diagnosis and follow-up (to decrease the need for travel), as well as for facilitating communication between hospitalized children and their families in northern communities. Universal childhood immunization, promoting good antenatal care, and co-operation with other community partners to ameliorate the socioeconomic status of Aboriginal families may also improve the health of Aboriginal children and youth.

**201**     *The Perception of Health Needs and Problems from the Community Perspective from the Municipalities of La Granja and San Ramón\**

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The Chilean Initiative in Health Equity initiated in 2005, a qualitative study looking at “Perceptions of health needs and problems” with the populations of the municipalities with little resources in Santiago: San Ramón y La Granja. This work falls under the logic of the “Participatory Health Diagnostic”, understanding that in it, people of the community participate in identifying and prioritizing their problems. These results allow for the improvement of municipal plans for health in responding to the health sanitary objectives of Chile and in reducing inequities in health and providing better user satisfaction.

**METHODOLOGY**

Descriptive design with qualitative research techniques. Four focus groups were conducted in each municipality. According to the register of social organizations in each municipality, a structural sample was designed to include the distinct profiles of which the municipality is comprised, formed by people who represent their reference group, in this case, users of the medical centres in the respective municipalities and medical centre employees.

**RESULTS**

The most important themes perceived as health needs and problems in general are: Firstly, violence and depression, indicated as much by the community as by the healthcare professionals. Secondly and very related to the first, are problems in inequity as a result of the lack of opportunities in obtaining better health due to work problems, layoffs, low salaries and poverty in general in the municipalities studied, generalizing inequalities. Thirdly and no less important, problems in health care services have been indicated such as waiting times, user-centred problems, lack of information and education.

**CONCLUSIONS**

The identified problems by the population correspond to social determinants of health. For local level planning, the identification and characterization of the social determinants of health are key in making decisions regarding the improvement of health in the municipality. These problems generate an impact at the individual level (private and familial) and on the collective (public and social) of the population which reflects on the need for local authorities of various levels and sectors to interact and coordinate to better satisfy the needs of the inhabitants of these municipalities, in respect to the impact on health.

79      *UNDERSTANDING MULTIPLE HEALTH INEQUITIES IN A DEVELOPING NATION: THE IMPORTANCE OF THE SOCIAL CONTEXT AND METHODOLOGICAL INNOVATION*

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Equity research would be incomplete without an understanding of how health inequities result from contemporary social processes and manifest in different social groups. The present paper highlights multiple health inequities in India in the context of the country's development and liberalization of its economy. In doing so, it not only dwells on conventional equity 'stratifiers' like class and ethnicity but goes beyond to present a case for groups like the migrants. It also argues for methodological innovation in the generation of evidence on health inequities.

India (in South Asia) has commonalities with many developing nations, having gained independence from colonial rule in the 1940s and embarked on the development mission thereafter. Like most multicultural societies, India too is characterized by marked cultural and socio-economic diversities of caste groups, class, tribes, religion, etc. The complex interplay of various socio-historical forces in such a diverse setup has created /perpetuated multiple health inequities in the country. India's history of governance, the 'development' project that it has engaged in since the 1950s, the communalisation of Indian Society and more recently, the liberalization of the Indian economy have had differential effects on the different socio-economic groups in the country. The health status of many disadvantaged groups in India is grossly inferior to that of its privileged social groups. There is inequitable access to basic determinants of health like food and water among the country's disadvantaged groups. Conventional demographic indices (e.g. infant and child mortality rates) and prevalence of infectious and communicable diseases among such groups are very high. Access to healthcare is highly skewed in favour of the urban elite in a predominantly rural nation. Emerging evidence also suggest how the development and the liberalization processes have compounded health inequities in the country, by adversely affecting social groups like the migrants.

The present paper systematizes available evidence on such health inequities among the various social groups in the country. It argues that in any enquiry into health inequities in the country, it is necessary to be informed by the socio-historical context and widen our focus beyond the conventional categories of class, caste, rural-urban and gender to include groups like the migrants, the differently abled, and others among the disadvantaged. Citing evidence, it is stated that, survey research needs to be complemented by qualitative and participatory tools to understand the health inequities experienced by disadvantaged groups in the country.

**200**     *HEALTH INEQUALITIES AND SCHEDULED TRIBES IN KERALA, INDIA*

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**OBJECTIVES:** To measure inequalities in health and health determinants 1) between Scheduled Tribes and the general population and 2) among Scheduled Tribes.

**BACKGROUND:** Kerala reports the highest level of human development among the Indian states. However, these average indicators provide insufficient knowledge to assess inequalities within Kerala. One group identified for their higher level of deprivation are Schedule Tribes (STs) or Adivasis. STs are India's indigenous population and encompass a variety of tribes. Disparities between the STs and general population have been illustrated for living conditions and literacy, yet we have little evidence documenting the distribution of health and determinants of health. We also know little about the potential variation among tribes.

**DATA SOURCE:** Household survey of an entire Panchayat (administrative unit) in northern Kerala (N=3,352 households), including demographic, socioeconomic, and health information.

**DATA ANALYSIS:** Intergroup disparities are measured through simple range measures (relative risks, rate differences, rate ratios) and odd ratios (obtained through multi-level logistic regression models, controlling for household and ward).

**KEY FINDINGS:** 1) Health and determinants of health are unevenly distributed across social groups, STs report the poorest health, have the poorest living conditions, experience the highest rates of exclusion to health care, spend the greatest proportion of their household expenditures on alcohol and tobacco, 2) important heterogeneity exists among STs, one tribal group (Paniyas) are particularly vulnerable to illness and impoverishment; the Paniyas (a historically enslaved group) have absorbed an inferior status and lack the capacity to aspire (which has implications for measuring their perceived health status).

**POLICY IMPLICATIONS:** Public policies and interventions should recognize the diversity of needs among STs and target the most vulnerable groups.

**Funding:** International Development Research Centre (IDRC) Canada.

36 *Health and Inequity: the Case of Mexico*

**OBJECTIVE:** This paper studies through an econometric model, health's public financing ways and its relationship with health, income inequality and gross domestic product per capita for the case of Mexico, during the period 1980 – 2002.

**METHODOLOGY:** It is presented a time series regression model, that analyses gross domestic product per capita and the income inequality index Gini over two most important indexes of health level as mother and children death rate. Also, the relationship among health's public expenditure, income per capita and income inequality is studied. The Box and Jenkins methodology is used (ARIMA, AR for autoregressive, I for integrated, MA for moving average), the functional form is double logarithm, the coefficients obtained in this way can be interpreted like elasticities (% change of variation of the dependant variable, while 1% change of the independent variable). The importance of this methodology consist on of that measure of the evolution on health level in a large period of time. So, three individual equations are estimated

$$\text{HPE} = 0.62 \text{ GDPpc} - 0.83 \text{ GINI} \text{ ec.1}$$

$$\text{MDR} = -0.27 \text{ GDPpc} + 0.52 \text{ GINI} \text{ ec.2}$$

$$\text{CDR} = -0.25 \text{ GDPpc} + 0.45 \text{ GINI} \text{ ec.3}$$

where: MDR is the mother death rate, GDPpc is the gross domestic product per capita, GINI is the income inequality index, HPE is the health public expenditure.

**RESULTS:** It is found that there is statistic inverse relation between the HPE and the GINI with a elastic value of  $-0.83$ , for each 1% that GINI increases the HPE will decrease in 0.83% or vice versa, for every 1% of diminution in HPE, the GINI will increase in 0.83%. In consequence, the diminution in 1% of the health public expenditure will increase the MDR and the CDR trough the GINI index, in 0.52% and 0.45% respectively. The economic growth, measure for GDPpc will impact positively the HPE in 0.62%, and negatively over the MDR with  $-0.27\%$  and over CDR with a coefficient of  $-0.25$ .

**CONCLUSIONS:** The diminution on health public expenditure will increase the income inequality, having as a consequence an increment of the CDR and MDR; when the gross domestic product raises it has favorable effects over the increase of health public expense and the diminution of the death rates. The objective of a better functioning of Mexico's health system will not be achieved on the basis of a system that operates under large income inequalities and the diminishing of the health's public expenditure.

144 *A new political economy of equity in health and health care*

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This paper argues that the economic analysis of equity in health and health care needs a new paradigm. The existing economic theories are inadequate for any comprehensive, rigorous consideration of equity, particularly as they are driven by individual preferences. Too many analyses of equity have failed to examine the equity implications of the social determinants of health, of many macro issues and of globalisation. It is argued that placing the value system underlying equity into the hands of the community rather than individuals, adopting a communitarian stance, provides a more useful paradigm. The concept of 'communitarian claims' is adopted. This recognizes first that a duty is owed by the community to the disadvantaged and second that the carrying out of this duty is not just instrumental but is good in itself.

This paradigm requires that questions of culture and cultural values come into play. It uses the work of Amartya Sen and Martha Nussbaum on capabilities (but shifts these to a community level). It also draws on Nussbaum's work on social compassion.

It is recognized that the construct of health varies culturally. Communitarian claims allow equity to be pursued without having to have a common construct of health (or health need) as is the case for many approaches to equity.

A central theme is that preserving the diversity of cultures requires the diversity of economic systems. This leads to a critique of both neo liberalism per se and the hegemony of neo liberalism. This allows the author to spell out a new paradigm for equity in health and health care. The focus is firmly on community and culture.

The second half of the paper will examine some of the practical implications of this paradigm. This is done first in the context of Australian Aboriginal health, policy for which in recent years provides an example of the failure of 'standard' equity approaches; and second in more mainstream and international terms when citizens are allowed to influence policy on equity.

Considerations as to how to get at community/citizens' values are set out.

The new paradigm is based in political economy and as such involves a cross disciplinary approach.



185 *INVERSE CARE LAW: A MICRO LEVEL EXAMPLE IN AUSTRALIA*

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In Australia it has been estimated that over 1.2 million individuals (6% of the population) experience sleep disorders, with costs of \$10.3 billion being attributed to these conditions in 2004. The most common disorder is Obstructive Sleep Apnoea, affecting an estimated 4% of the population; although there are over 70 other diagnosable sleep disorders. Insomnias are also highly prevalent (second most common). Substantial morbidity and mortality is associated with these conditions and over the past 30 years, increasing recognition of the short and long-term health impacts has been paralleled by increased demand on clinical services to diagnose and treat. This is highlighted by the sharp increase in laboratory-based formal overnight sleep studies conducted annually in Australia, from 14,308 in 1994 to 65,289 in 2005. These occurred in 79 adult (non-pediatric) clinical sleep laboratories Australia-wide. We propose that in Australia there is a growing case of inverse care in the provision and availability of sleep disorder services. Sleep disorder clinics that operate in private hospitals significantly outnumber clinics that exist in the public hospital sector. Specifically, of the 79 clinics, 19 are public, 56 are private and four offer combined services. This is a ratio of almost 3 private facilities to every 1 public facility. Inverse care exists as only 42.9% of the Australian population is covered by private health insurance (2005). Therein, approximately 70% of the diagnostic and treatment capacity in Australia services a minority of 42.9% of the population (those with private health insurance). Conversely, 30% of available facilities service the majority, 57.1% of the population who do not have private health insurance. Not surprisingly, inverse care is thus represented in waiting times, wherein a wait of 21 (range 4–68) weeks exists in the public sector compared to 4 (range 1–12) weeks in the private sector. To further accentuate this anomaly in care we point to the very real and widely documented socio-demographic gradient that exists for the prevalence of many health conditions. We might reasonably argue that a greater burden of sleep disorders (and their associated negative health outcomes) is likely to exist in those who are most unable to afford private health insurance. This very real micro example of the Inverse Care Law has implications for the capacity of the Australian health care system at a macro level to reasonably and equitably accommodate the health needs of the entire population, and indeed those most vulnerable within it.

**169** *Applying the equity gauge approach in an urban slum setting: what have we learnt? (GEGA Panel Presentation)*

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**INTRODUCTION**

An equity gauge is an active approach to address inequities that monitors equity and incorporates concrete actions to bring about sustained reductions in unfair disparities. It does this through three broad spheres of action: (a) assessment and monitoring to analyze, understand, measure and document inequities; (b) advocacy to promote changes in policy, programs and planning; and (c) community empowerment to support the role of the poor and marginalized as active participants in change. In a sense, an Equity Gauge not only measures or 'gauges' equity and inequality, but also triggers actions to reduce inequities. It requires the involvement of various actors (researchers, policy makers and implementers, the media, and the general public.). Inherent within the concept is that determinants of inequities are largely socio-political in nature, and often relate to unfair distributions of power, influence and wealth.

The paper synthesizes experiences, challenges and lessons learnt in applying the approach to address health inequities of the Nairobi Equity Gauge. This approach is relevant to institutions in research, advocacy and action in social outcomes.

**EXPERIENCES**

In addition to the finding that there are increased levels of sexual networks in Nairobi slums, the study found little or no access to public amenities such as health facilities and schools. The 1998 Demographic and Health Survey (DHS) provided an opportunity to compare these outcomes in slums, Nairobi and rural Kenya. Children in slum communities had worse outcomes than those in rural Kenya. The gauge built on these results to develop a partnership for action (pilot) with ITDG-EA, PATH, JEPIEGO, CCN and the Community to address child health through water, sanitation, and personal hygiene improvement.

Second, the gauge committed to providing scientific evidence for the media and did help establish a category in the Journalist of the year awards (through the Kenya Union of Journalists) for reporting on Equity.

Third, assembled evidence suggested that the leveling-off of fertility and contraceptive prevalence is likely to be a result of increasing unmet need, fertility and decreasing contraceptive prevalence among the poor. Within the collaborative framework of the Global Equity Gauge Alliance and EQUINET, champions within and without Kenya were identified.

The consultative process culminated in a meeting of parliament, senior government officials and development partners to discuss the stagnation of family planning indicators and actions to re-energize the efforts. An alliance to spearhead enlightening of members of parliament about equity and discussion of possible action was initiated...

**LESSONS**

First, actively lookout and maximize on all opportunities. Second, involve the stakeholders as partners in the process and make them sign onto specific deliverables. Third, always identify a champion at each stage. Fourth, build on from one stage to the next in a consistent and coordinated manner, and fifth, follow through with patience and determination.

**241**     *An Alcohol Abuse Early Intervention for First Nations' Adolescents*

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This paper describes the development of and pilot results for an alcohol abuse early intervention program targeting at-risk First Nations youth conducted in partnership with schools and communities. The intervention was based on traditional Mi'kmaq knowledge and teachings in order to make the program as meaningful and relevant as possible in the partner communities (Comeau, Stewart, Mushquash, Wojcik, Bartlett, Marshall, Young, & Stevens, 2005). It was based on previously established, successful psychoeducational approaches and cognitive-behavioral techniques for young drinkers from the majority culture (Conrod, Stewart, Comeau, & MacLean, in press). The pilot results were positive. Compared to pre-intervention, students who participated in the intervention drank less, engaged in less binge-drinking episodes (i.e., 5 drinks or more/occasion), had fewer alcohol-related problems, were more likely to abstain from alcohol use, and reduced their marijuana use at four-months post-intervention. No such significant changes were observed in a non-random group of eligible students who did not participate in the intervention. Future research should determine if this intervention is effective for at-risk youth in other First Nations communities across Canada, and whether the promising, but preliminary results with marijuana mean that the benefits of the intervention might extend to adolescents' use of substances other than alcohol, even though alcohol was the targeted substance of use.

192 *Socially disadvantaged castes and poor health: how strong is the relation in Kerala?*

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**OBJECTIVE:** Kerala is well known for the equitable provision of basic services- water supply, sanitation and health care. The paper discusses two issues: has the equitable provision of services altered the well known poverty – poor health relationship? Does health status show a gradient with social disadvantage?

**METHODS:** Cross-sectional data from a household survey of 3350 households implemented in 2003 has been used, wherein demographic, socio-economic, and health data are collected. Study population: Non-elderly women and men (18-49 years); Response variable: Self perceived health. Respondents were asked to rate their overall self-perceived health based on a five point likert scale: very bad, bad, good, very good, excellent. We collapsed the variable into 3 categories due to distribution of data: very bad/bad, good, very good/excellent. Explanatory variables used: gender, education, and size of land holding. Age-adjusted percentages of bad health were computed. Multilevel multinomial logistic regressions have been run controlling for age. Two level models (individuals at level 1, caste | tribe of head of household at level 2) where 8398 individuals are nested among 35 caste | tribe.

**FINDINGS:** Age adjusted odds ratios are significant for bad health, and good health (ref: excellent health) for women (ref: men), no education, primary education (ref: high school plus), land holding less than 10 cents, and 10 to 50 cents (ref: above 50 cents). While bad health is largely explained by the individual level factors, good health shows a strong residual caste gradient. As caste is an indicator of social disadvantage, this would suggest a health gradient with social disadvantage.

**CONCLUSION:** Social gradient in health is present in a poor society with equitable water supply and sanitation. Education and income variation explain only part of the gradient leaving a large part to be explained by social disadvantage.

**Key words:** social disadvantage, Kerala, health, equitable provision of services.

**125**     *HEALTH EFFECTS OF JOB LOSS FROM A AUTOMOTIVE PLANT*

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Around the world transnational corporations are withdrawing capital from communities in which they have had long term commitments and been providers of mass employment. This paper will report on data from the first wave of interviews from a longitudinal study of the closure of an automotive manufacturing plant in Adelaide, South Australia.

The study is based on detailed structured interviews with 380 workers exiting from the manufacturing plant and in-depth interviews with 40 of them. The research is a collaboration between housing, labour market and public health researchers and the interview collected data relating to each of these topics. The public health arm of the study was particularly interested in the extent to which social capital influenced worker's experiences following retrenchment.

This paper will draw on data addressing the issue of whether individuals' levels of social capital appear to buffer the effects of losing one's job and the extent to which losing one's job is perceived as having an impact on health by the workers. We will report on the range of experiences reported by our sample and represent typologies of workers based on their health status at the time they lost their job; their reactions to the situation and the extent of their social support.

The paper will conclude with discussion of the implications of our early research results for policies relating to the closure of manufacturing plants that are significant employers in a community and the responses that may be expected.

**170**     *GEGA: Some joint initiatives (GEGA Panel Presentation)*

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This concluding presentation will describe combined initiatives of Equity Gauges as part of GEGA.

**Health Equity: Research to Action** course is focused on developing evidence-based responsive action to support pro-equity policy development and community empowerment and is designed to support the development of programmes of work to enhance uptake of pro-equity policy, at national and local levels. It is also intended to encourage sharing of information and experiences among participants, and provide opportunities to link with a larger community of researchers and advocates working in health equity internationally. Ultimately, the course is intended to support the development of additional Equity Gauges and GEGA partners in developing countries. An update will be given on courses that have been organized in different regions of the world.

**Equity and Health Systems** course: Mainly an initiative of GEGA's South Asian Equity Gauges, the course is a first step towards developing a South Asian Health Equity Network and is envisioned to provide a platform for scholarly exchange in the region. Through the network a pool of researchers will be created to work on issues of health equity in the region. Piloting of the course is planned for January 2007.

**Southern and East African Parliamentary Alliances Committees on health:** Through this initiative, GEGA along with EQUINET, aims to co-operate with key institutions to: strengthen and provide information and resource inputs for partnership between parliament, professionals, and civil society to work towards building a common platform for health equity; and support networking of parliamentarians through their Portfolio Committees on Health to enhance common work on health equity at the national level in several countries.

**The Global Health Watch** was initiated by partners at the global level including GEGA, Peoples Health Movement, MedAct, and CEAS with the aim to mobilise the health community around an equitable and rights-based global public health agenda and to improve and support effective, democratic and rights-based global health governance. The Watch is intended to improve and support global health governance by: providing a platform to express a civil society perspective on the state of global health and, by incorporating a public accountability function – by monitoring the actions and policies of several key organisations, institutions and partnerships that influence the state of global health. GHW1 has demonstrated that monitoring key institutions which have an impact on health is both desired and appreciated by academics, non-government organisations and policy makers.

68 *Inequalities in smoking: influence of social chain of risks from adolescence to young adulthood, a prospective population-based cohort study*

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This study investigated pathways of social risks at different life stages that are linked to smoking initiation and maintenance at age 30. A cohort consisting of all pupils ( $n = 1083$ ) from one Swedish city were followed from age 16 to age 30 (1981–1995), with a 96.4% response rate. Odds ratios of being a smoker at age 30 among low educated were 2.54 for men and 2.53 for women. Using structural equation model analysis, for men and women a strong chain of risks was found from age 16 linking to smoking at age 30: adolescents with adverse socioeconomic status (SES) were more likely from a divorced family. Being from a divorced family and having poor contact with their parents influenced their smoking directly and through peers. Adolescents with adverse SES were also likely to be unpopular in school, which affected their smoking behavior directly and through peers. These socially disadvantaged participants, who were smokers at age 16, continued smoking until age 30 years. Adult smoking reflects the cumulative influence of multiple socioeconomic and psychosocial chains of risks experienced during upbringing. The programs that are addressed to reduce smoking among socially disadvantaged adolescents would have an impact in reducing smoking inequalities in adults.

67 *Striving to achieve gender equality in Chlamydia testing*

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**BACKGROUND:** The number of cases of genital Chlamydia trachomatis is increasing steadily in the world despite current preventive measure. Chlamydia infections being mostly asymptomatic and untreated can lead to infertility among women and men poses a challenge to the health care. Today over 75% of all chlamydia tests are taken by females in Sweden and young sexually active men are difficult to reach in Chlamydia screening programs. Successful control of Chlamydia and is dependent upon gender equal testing of men and women. The object of this study was to use a new Internet based self selective testing approach by means of home sampling in the general population in Sweden with an aim to reach gender testing equality.

**METHODS:** Observational survey of people actively ordering coded testing packages, and checking their test results, from a known web site. No personal invitations were sent out. All inhabitants (256 885 men and women) in a Swedish county were eligible to participate. A special interest was taken in coverage, gender distribution, participants' chlamydia prevalence and determinants for infection.

**RESULTS:** Testing was highest in the age group 20-24 years where 298/9495 (3.1%) of all women and 171/9574 (1.8%) of all men in the population participated. Forty percent (364/906) of the tests were from men and 60% (542/906) of the tests were from women. In the age group 25-34 years 55% of the tests were from men. The prevalence of Chlamydia trachomatis infection was 6.0% (95% CI: 8.4% to 3.6%) among male participants and 4.6% (95% CI: 6.4% to 2.8%) among female participants. Prevalence increased with decreasing age. Believing to be infected and having symptoms were the strongest determinants of infection.

**DISCUSSION:** Simplifying and increasing the accessibility of chlamydia testing by means of Internet and home sampling proved feasible. Self-risk assessment improves the chance of finding persons infected by Chlamydia trachomatis especially among men, if an accessible testing method is offered. This new method can serve as a supplement to regular preventive methods achieving a more gender equal testing rate.



**15** *PLANNING HEALTHY AND SUSTAINABLE CITIES IN AFRICA*

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Poverty reduction dominates the international development agenda of the 21st century. The Millennium Development Goals underline the need to significantly improve the lives of millions of slum dwellers around the world, and to reduce the number of people without sustainable access to drinking water and sanitation. With the dramatic increase in the numbers and proportion of people living in cities in Africa, urban slums and irregular settlements have become so pervasive that they now outnumber legally planned developments, and their social legitimacy appears to be no longer in question; however, the appalling environmental conditions associated with these settlements constitute a major threat to the health and well-being of the urban community. The WHO emphasizes that it is the home, not the clinic that hold the key to a better health delivery system.

The main policy challenge addressed by the paper is how best to support and regulate the urban informal sector and irregular settlement in a way that promotes employment, income and shelter for the poor, and at the same time ensures a safe, healthy and socially acceptable environment; how to ensure that the legitimate concern to fight urban poverty and slum dwelling does not result in blaming the victims, and in a campaign against the urban poor and slum dwellers themselves. How can future slums be prevented and the existing ones upgraded and progressively integrated into the urban mainstream. The paper argues that human development ought to be at the centre of the concern for urban sustainability, and that the proper starting point in the quest for urban sustainability in Africa is the 'brown agenda' to improve the living and working environment of people, especially the urban poor who face a pressing environmental threat to their health and well-being. This human development approach calls for rethinking and broadening the narrow technical focus of conventional town planning and urban management in order to incorporate the principles of urban health and sustainability embodied in Agenda 21, the Habitat Agenda, and such other global initiatives as WHO's Healthy Cities Programme, the World Bank's Cities Alliance for Cities Without Slums, the UN-Habitat's Campaigns on Urban Governance and Secure Tenure, and so on. The study is based on documentary, library and internet research, and on extensive interviews and interaction with various urban stakeholders, including the urban poor.

The concluding section considers the main elements of a strategy to achieve better functioning, healthier and more inclusive cities, stressing the roles which state and local authorities should play, and the need for the international development community to genuinely address the global economic context of underdevelopment, and the structural roots of urban poverty in Africa.. It also considers how the urban poor and informal enterprises could better organize and self-regulate themselves in order to engage more constructively with government and other development partners. It ends with some general reflections on the future of the African city, what form it will take, and how to bring about the changes needed to make the cities healthier, more productive, more equitable, and better able to serve people's needs

134 *SOCIAL CAPITAL AND WOMEN'S MENTAL HEALTH*

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There is a marked gender inequity in the distribution of common mental health problems in Australia, including depression and anxiety disorders, with women experiencing higher rates. This paper considers how the concept of social capital can contribute towards an understanding of the social factors which determine women's mental health outcomes. As part of a broader study, qualitative research was conducted to explore women's experiences of social participation and accounts of their own mental health. In-depth semi-structured interviews were conducted with 30 women in two case study areas in metropolitan Adelaide. One case study area is an affluent neighbourhood, the other relatively disadvantaged. Participants' social capital was explored by focusing upon their experiences of involvement in Civil Society Groups (CSGs), such as voluntary clubs and organisations, and the individual outcomes of this involvement. Interviews were conducted with 15 women in each location. The findings indicated that women's participation in CSGs was organised in highly gendered ways. The degree of individual women's participation in CSGs, the type of participation, and participation outcomes all varied according to the local neighbourhood and individual socioeconomic factors. Participants' involvement in CSGs and the outcomes of this involvement were perceived as having both positive and negative consequences for mental health. These findings lend support to the notion that individual social capital is differentially distributed according to features of the wider societal context. The potential for the concept of social capital to contribute towards promotion of gender equitable mental health outcomes is discussed.

**103 EQUITY - A PREMISE FOR EFFICIENCY IN HEALTH**

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Choices should be made as increased demand for health care services is met by budget constraints. Therefore the issues of Efficiency - achieving best results with given resources - are paramount. When different policies compete for funds, what theoretical foundation for resource allocation in relation to health will lead to Efficiency? For utilitarianism the best resource allocation is the one that maximizes the sum of individuals' utilities. Some say that we can have either Equity or Efficiency, but not both. I have established that in relation to health the utility is two-dimensional: utility of the consumer of health care services and utility of those who finance health care collectively (the society). Financial, organizational and political sustainability requires that utility maximization in relation to health should consider both: individuals' and society's preferences. Ignoring the preferences of those who finance health care collectively inevitably leads to Inefficiency. When applied in relation to health, Pareto Optimality and Kaldor-Hicks criterion need a clarification.

I suggest that in order to maximize utilities in relation to health Equity and Efficiency can not be separated. Once interdependence of equity and efficiency is acknowledged, it is important to determine what will be more efficient for maximizing of public health – redistribution of income or redistribution of services. I state that only distribution of benefits-in-kind ( health care and social programs and services ) can take into account society's preferences. However, biomedical model of health can not address all determinants of health. Hence benefits-in-kind based only on biomedical model can not be successful in achieving allocative efficiency. Thus importance of social determinants of health should be recognized and benefits-in-kind should address those as well, in order to achieve allocative efficiency as premise for utility maximization. If a society, which declares that all people are of equal value, wants utility maximization in relation to health, than Equity is a premise for it.

209 *Health seeking and spending of people in an urban poor neighbourhood in the Lower North of Thailand*

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**BACKGROUND:** The universal health coverage policy has provided access to government health delivery system with minimal copayment, but the poor may be less readily accessible to the policy by various reasons. This research wanted to follow health seeking and spending of poor people over a year period.

**METHOD:** Households in an urban poor neighbourhood in Phitsanulok were interviewed four times over a 12-month period.

**RESULT:** About 113 households were interviewed in the first waves but the number dropped to only 59 household in the fourth wave due to high migration. People in this urban area sought care both in public and private health facilities. The poor households were likely to report more illness over the four waves of interviews. Private health facilities were accessible by some households. Financial problem was not a major problem but depletion of household assets among illness household was observed.

**CONCLUSION:** Access to care under the universal coverage policy may be revised to provide better access especially to the poor.

210 *Reviews of health information systems for monitoring health equity help reduce redundancy and enhance equity policy development in Thailand*

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**BACKGROUND:** Health equity was a major motive for universal health coverage policy in Thailand in 2001. In order to achieve higher equity goal, effective health information systems for monitoring health equity are needed.

**OBJECTIVES:** To review existing health information systems that can be used for monitoring health equity. The information systems cover both community surveys and administrative database at the national level.

**METHODS:** Literature and documentary reviews complementary with peer review meetings.

**RESULTS:** Literature reviews emphasise the importance of having concise definitions of health equity. The health equity policy goals indicate the need for measuring health disparities and drive relevant constituencies to design interventions as a remedy to disparities. Documentary reviews of final reports and questionnaires of the national health surveys found 19 surveys by the National Statistical Office, the Ministry of Public Health and academic institutions. These surveys had potential variables that could be used to demonstrate health disparities by subgroups however they contained overlapping data elements but with different interpretations and measurement standards. Reviews of routine databases for health systems management found 9 data systems with potential uses for monitoring health equity. Peer review meetings were held to validate the results of documentary reviews. About 30 experts from responsible organizations were invited to the meetings. They realised the abundance of existing databases and agreed to insert important variables for next rounds of surveys or work processes. They also suggested equity policy questions from the existing data systems for national policy makers, health care providers and the community at large.

**RECOMMENDATIONS:** Further actions for Thailand include harmonisation and standardisation of the national health surveys; insertion of relevant patient characteristics to administrative data. Equity gaps should be published regularly from these data sources to guide further national, provider and community policy interventions.

**18**      *SEXUAL MALTREATMENT OF UNACCOMPANIED CHILD REFUGEES*

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**OBJECTIVES:** The SAFER UK study aimed to identify how sexual abuse and sexual assault of asylum seeking unaccompanied minors can be prevented and how professional interventions can be made more culturally competent.

**METHODS:** Data was collected through in-depth interviews and self-completion questionnaires from 53 young adults (51 females, 2 males) who experienced child sexual abuse, sexual assault or a near miss in the UK who arrived here from Ethiopia, Somalia and Eritrea as unaccompanied minors; and in-depth interviews with 8 key professionals. Data were both qualitative and quantitative. The preliminary analysis of quantitative data was undertaken using SPSS to obtain frequencies.

**PRELIMINARY FINDINGS:** Incidents ranged from sexual harassment to rape and were often multiple. Perpetrators (usually strangers, often multiple) frequently attempted to lure them with rewards. Risk factors include: proximity of young males; inappropriate housing; lack of knowledge of UK culture and welfare system, the dangers of abuse and their rights; poor English; being without family; loneliness; poverty; and being female.

Many (n=17) told no-one often because of 'cultural reasons', were afraid to tell or did not know how; 4 reported the incident to the police; 29 told a friend; many had no one to tell. Professionals they disclosed it to were sometimes reported to take no action.

Common after-effects included headaches (n=13), mental distress (n=39), persistent nightmares (n=28), poor self-esteem and self-confidence (n=33), difficulties with relationships (n=28); sexual problems (n=20). Many had felt life was not worth living (n=25); nine had self harmed; some reported difficulties integrating (n=11) and eating disorders (n=17).

Under half (n=23) sought professional help mainly from Social Workers (n=14) and GPs (n=7). Some have since had counselling/ psychotherapy (8) or psychiatric consultation (7).

**CONCLUSIONS:** Prevention involves protecting particularly young female asylum seekers by providing single sex housing, more foster care, support and supervision; education on arrival about sexual abuse/ assault and their human rights; and advice and encouragement to report events to professionals and the police; and action taken. Counselling is not usually sought by East Africans who prefer less formal more culturally familiar alternatives.

**1.47 THE MEASURE OF INDIGENOUS RACISM EXPERIENCES (MIRE) INSTRUMENT**

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There is emerging evidence for the detrimental effect of self-reported racism on health among minority populations around the world. Nascent research in this area includes numerous instruments which utilise a range of approaches to measuring racism. However, the conceptual bases and psychometric validity of these instruments are rarely discussed in the published literature.

The Measure of Indigenous Racism Experiences (MIRE) was developed in response to an identified need for an instrument which was applicable in an Indigenous Australian context and which assessed multiple facets of racism, including reactions/responses to racism. The 31-item MIRE is, to our knowledge, the first instrument to be developed for an indigenous population that assesses self-reported inter-personal, internalised and systemic racism together with cognitive/behavioural responses and affective/somatic reactions to this racism.

This paper briefly describes the development and conceptual basis of the MIRE along with the results of a pilot study of the instrument. The MIRE was piloted in a subgroup of 312 participants in the Darwin Region Urban Indigenous Diabetes (DRUID) study which included Indigenous people aged 15 years and over who lived in a private dwelling in and around Darwin, Australia. This cross-sectional study included a health examination involving the collection of blood and urine samples, clinical and anthropometric measurements and the administration of questionnaires relating to health status as well as socio-demographic, psychosocial and behavioural characteristics.

Between 25% and 45% of participants reported experiencing racism in each of nine settings, with 70% reporting racism in at least one of these settings. Psychometric assessment of the MIRE component scales using Cronbach's  $\alpha$  and exploratory factor analysis suggested a good match with a priori theoretical constructs. Results of  $\chi^2$  tests of association between scales conformed to expected relationships among MIRE items/scales and there was also support for convergent validity with a separate single-item measure of discrimination. Regression analyses of the MIRE in relation to various health outcomes available from the DRUID (adjusted for confounding) were broadly consonant with emerging patterns in this field.

This pilot study indicates that the MIRE effectively assesses multiple facets of racism together with a diverse set of responses/reactions to this exposure. The MIRE both models good practice in the documentation of instrument development in this field and contributes towards redressing the virtual absence of indigenous populations from the study of racism and health.

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**40**      *UTILITY STRESS AND HEALTH STATUS IN A REMOTE ABORIGINAL COMMUNITY IN SOUTH AUSTRALIA.*

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This paper provides a case study on the relationship between utility stress and health status in a remote Aboriginal community in South Australia. It reports on findings from a focus group held with community members as part of a larger study exploring perceptions on water supply in 12 Aboriginal communities across South Australia.

In 1998-1999, 16.1 % of Australian households reported 'utility stress'. In the last year they were unable to pay either electricity, water, telephone, or gas bills by the due date because of a lack of money (Committee for Melbourne 2004:5). Those most at risk included the aged, people living alone or as a single parent, young people, the disabled and chronically ill, those living in transitory accommodation, non-English speaking migrants and Indigenous people (Lawrence 2002).

Many factors determine and influence the level of health experienced by people. There is a growing understanding of the crucial role that social factors in our society and in our living conditions play in generating disease and producing health inequalities. These social factors have become known as the social determinants of health. This paper explores the relationship between poverty as a social determinant of health and utility stress, specifically water, experienced by Indigenous groups in remote towns in Australia. The Committee of Melbourne report (2004) notes that the 2001 census identified that 72% of Aboriginal people were in the bottom 40% of household income distribution with an increase to 92% in remote regions.

Some of the issues discussed include the:

- strategies people experiencing utility stress, and poverty more generally, use to manage their utility obligations;
- impact of utility stress on Indigenous Australians health and wellbeing;
- poverty trap, for example, the higher utility costs associated with living in old, cheap or remote accommodation;
- ways in which water (one utility service) is understood by Indigenous communities and;
- the implications of the changing governance of water in Australia.

We argue that a number of factors have led to utility stress. These include privatization of public utilities and the reduction, and cost cutting of public housing. Policy makers need to ensure that low income groups, especially Aboriginal people, are able to access appropriate rebates in order to reduce utility stress.



96 *Imagine hope? Reflections on gender, health and human rights*

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This paper discusses the potential value of the human rights approach to address gender inequities in health in the global world. Health and human rights is an emerging field of research and action premised on the Universal Declaration of Human Rights and subsequent international human rights legislation which States all over the world have subscribed and committed to. Under international human rights law governments are responsible for both not violating rights and for ensuring the conditions which enable individuals to realize their rights as fully as possible. Thus looking at health through a human rights lens has the potential of granting a normative and strategic basis upon which to mobilize and render governments accountable in the pursuit of equity in health.

Gender disparities in social, economic and political resources are found in almost every society in the world, negatively affecting the health of women. However, as feminists have pointed out, the human rights framework often fails to recognize and address these structural inequalities, rather assuming that all people are equal in relation to all rights. Furthermore, conventional interpretations of international human rights law are androcentric and tend to reflect the experiences and interests of male elites while ignoring or neglecting the realities of women's lives. Asserting legal rights for women may thus be insufficient when a much broader and profound socio-political change is needed.

In this paper I argue that three critical issues need to be considered in order to make the human rights paradigm an effective tool in addressing women's health inequities in the global world. First, it's important to challenge narrow, male-centered definitions of rights, and broaden the human rights discourse to make it more reflective of women's lives, experiences and concerns. Second, it's necessary to ground the understanding of human rights violations in broader analysis of power and social inequalities, to uncover and expose the systemic and structural disadvantages that women experience in different societies and examine how they in turn affect women's health and well-being. And finally, it is necessary to strengthen the enforceability of international human rights law through legal mechanisms and continuing political action and pressure at local, national and global levels. These complementary strategies will enhance the legitimacy and efficacy of applying the human rights framework to promote and achieve gender equity in health.

115 *Ehara tau toa I te toa takitahi,  
Engari, he toa takitini e.*

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#### BACKGROUND

The National Heart Foundation's "Pick the Tick" programme aims to provide a guide to healthy food choices. Consumer awareness of the "Pick the Tick" programme is high and the proportion of consumers claiming to use the Tick to guide food choices increased from 43% to 55% from 1997 to 2000. However, it is believed (although not empirically demonstrated) that the "Pick the Tick" programme is most effective in high socio-economic groups rather than lower socio-economic groups or Maori and Pacific groups, thus widening health inequalities. This research provides evidence of the effectiveness of "Pick the Tick" for Maori, Pacific and low-income peoples in Aotearoa/New Zealand.

#### OBJECTIVES

This research aims to provide evidence of the effectiveness of "Pick the Tick" for Māori, Pacific and low-income people. The main research questions are:

1. Are Māori, Pacific and low-income people aware of "Pick the Tick", what are their attitudes to it, and do they use the Tick to guide food choices?
2. What improvements could be made to "Pick the Tick", or alternatives put in place, to meet the needs of Māori, Pacific and low-income people?

#### METHOD

The research was carried out through the use of focus groups to explore the effectiveness of the "Pick the Tick" programme and to suggest alternative approaches that may be needed. Six focus groups were conducted among food shoppers, stratified as follows:

- Two Māori groups
- Two Pacific groups (one Tongan and one Samoan)
- Two low-income groups, of mixed ethnicity

#### RESULTS

Little literature exists evaluating "Pick the Tick" as a guide to making healthier food choices, particularly lacking is evidence of whether the program is effective for different population sub-groups. "Pick the Tick" is perceived to be associated with higher-price food items, and therefore is seen as unaffordable by low-income people. An evaluation of "Pick the Tick" is discussed, as well as alternative approaches to making healthy food choices easier.

#### CONCLUSION

It is important to have evaluative processes in place for food labeling programmes in order to measure whether they meet the needs of all population groups. Promotion of healthy eating needs to be culturally appropriate, as well as practical for low-income people.

**72**      *Cochrane Collaboration, equity and public health: What works?*

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We lack evidence of effectiveness on public health interventions. Only 4% of Medline citations are relevant to public health. Furthermore, there is little evidence available on whether public health interventions benefit the poor and disadvantaged. Indeed, there is reason to suspect that many of our public health interventions preferentially benefit the most affluent and least poor in both low and middle income countries as well as industrialized countries. For example, the World Bank assessment of equity in 56 countries revealed almost 50% less use of known effective public health interventions in the poorest quintile compared to the least poor.

The Cochrane Equity Field and Cochrane Health Promotion and Public Health Field are working together to conduct systematic reviews to assess whether interventions introduced in the name of the poor are indeed benefiting the poor.

We developed criteria for demonstrating efficacy on reaching the poor that include size of effect in the disadvantaged compared to the least disadvantaged (equity ratio), overall size of effect and quality of study design. We define equity across PROGRESS factors of Place of residence, Race/ethnicity, Occupation, Gender, Religion, Education, Socioeconomic status and Social capital.

We have identified a list of interventions that have demonstrated efficacy at improving the health of the poor in both low and middle income countries (e.g. social marketing of bednets, participatory programs for sexual health) and in high-income countries (eg bicycle helmet legislation, daycare for children). We discuss the differences in targeting the poor versus population-wide initiatives, and the sustainability of these initiatives at country-level.

71 *Assessing equity-effectiveness in systematic reviews*

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Systematic reviews of all available evidence are increasingly recommended as the primary source for evidence-based decision-making. Indeed the Mexico Ministerial Statement on Health Research, adopted by the World Health Assembly, recommended using systematic reviews as the basis for decision-making. However, systematic reviews have historically focused on average effects, which ignore the distribution of benefit and whether interventions benefit the poor and disadvantaged. Indeed, we have recently shown that community effectiveness of interventions is substantially lower in disadvantaged groups due to a staircase effect of lower coverage, poorer diagnostic accuracy, lower provider compliance and worse consumer adherence.

The Cochrane Equity Field has developed methods for assessing whether and how to assess equity as part of systematic review process, and evaluated the added-value of assessing equity implications for relevant reviews.

We developed an “equity plausibility index” for whether equity should be considered for systematic reviews, using the acronym PROGRESS to define equity factors which are Place of residence (rural/urban/inner city), Race/ethnicity, Occupation, Gender, Religion, Education, Socioeconomic status and Social capital. Criteria include: 1) likelihood of equity differentials in efficacy; 2) likelihood of equity differentials in implementation effectiveness because of differential preferences, values, beliefs or access of consumers or providers across PROGRESS factors. These criteria were validated by an advisory board of equity experts. We then identified a 10% random sample of systematic reviews published on the Cochrane Library, stratifying by review group and year of publication (in 5 year brackets) to ensure diversity of topics and time of publication. We applied these criteria to identify candidate systematic reviews where equity should be considered in implementation or efficacy assessment. For those where equity was considered important, we appraised the evidence using an Equity Checklist on searching for relevant studies, quality appraisal, types of studies and analysis, including magnitude of equity impact and quality of the equity-impact recommendation. We also documented the time required to add equity information for each review. We then asked our advisory board to rate the value of the additional time and effort required to include equity information in the systematic reviews, using a structured survey.

We present results on differential equity effectiveness and the subjective value of including this information for decision-making. These methods can be applied to ongoing systematic reviews or retro-actively to previously published systematic reviews to assess the effectiveness differential across equity factors.

**159**     *INTERSECTORAL ACTION FOR HEALTH IN DISADVANTAGED COMMUNITIES: WHAT WORKS AND WHAT DOESN'T*

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The recognition that many of the determinants of health are beyond the control of the health sector has driven health professionals to develop intersectoral partnerships to promote the development of supportive environments for health and minimise the elements that predispose communities to ill health. An intersectoral community-based intervention was implemented in a disadvantaged neighbourhood in South Western Sydney to improve health, safety and service delivery through community participation. A mixed-methodology evaluation was undertaken including cross-sectional randomised household surveys in 1999, 2002 and 2005 and qualitative interviews with key partners and community representatives.

In the first three years, the intervention developed through population level investments via urban renewal activities and community development programs. The intervention resulted in community perceptions of increased health, safety, amenity and perceived reductions in crime. Following a three year re-funding period and substantial changes in partnership structures, which saw a shift in investments to the provision of specific services to at-risk groups, significant increases in community perceptions of crime and decreases in perceptions of health and safety resulted.

This paper describes the findings of the evaluation in relation to the role of intersectoral community-based intervention in promoting healthy communities. It will provide evidence for discussion about the types of investments most likely to result in effective, efficient and sustainable change in health practice when seeking to address the underlying determinants of health in disadvantaged populations.

**100 COMMUNITY FOODIES- PEER EDUCATORS ADDRESSING NUTRITION INEQUITIES**

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The Community Foodies project aims to increase the access for marginal groups (particularly low income and aboriginal groups) to nutrition information and skills via a peer education model. It also provides a pathway to further education and employment for peer educators.

The project offers free training (24 hours) on basic nutrition and community education skills. Once graduated Foodies work with health workers to promote and advocate for healthy eating. This presentation will focus on how this project appears to be working toward addressing nutrition inequities for urban Indigenous communities. Five Indigenous women have trained as Community Foodies and one of these women will tell her story of how Foodies has impacted on her own experience of inequities. The main outcomes for this Foodie as with many others are 1) dietary changes leading to positive health outcomes such as an increase in birth weight of her second child and longer breast feeding, 2) increased personal empowerment, with this Foodie completing her schooling and now being employed with the Department of Education and Children Services.

Evidence gathered from a multi method approach, (using quantitative, qualitative and realist approaches) shows that the project is reaching low socioeconomic groups with 65 % ( N= 33) of participants ( N= 51) of Foodie programs, with an income less than \$25000 per annum. Also 59% ( N =35) of participants of Foodie programs (N= 59) had not previously attended a cooking/nutrition program, which indicates an extension of reach to new target groups. Interestingly those on low incomes (under \$25000 pa) benefited more in relation to the number of serves of fruit and vegetables eaten per day and in their sense of self esteem. This is a particularly important finding because experience in some health promotion programs (for example, quitting smoking) has shown that the less disadvantaged tend to benefit more than the disadvantaged, resulting in a widening health gap. In this program, there is some evidence that the disadvantaged have benefited more than the less disadvantaged.

Since intersectoral partnerships are an important principle of the project the evaluation is also investigating whether auspicing and partner agencies of the project consider Community Foodies are enabling them to reach marginal groups, and additionally achieve their strategic plans.

This project is thus showing early evidence of addressing nutritional inequities for marginal groups. It appears at this stage that the key to its success is the peer approach with the project model going further than education and skills to address poverty by providing a pathway to further education and employment.

The project's transferability to other situations would be dependent on ensuring that the project is grounded in the community, such that it works with and alongside the community. Adequate time and resources to comprehensively implement a community development process and continually support and increase the skills of workers is also critical to its success.

#### 4 ARGUMENTS IN FAVOR OF AN EMPOWERING COMMUNITY CAPACITY BUILDING IN HEALTH

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1. The notion of duty and justice (...and not compassion!) give the right to their cutting edge.
2. Power is the key relation in health and human rights (HR) issues. A right confers power, i.e. the power to make key changes as far reaching as the system allows claim holders to do so. (...and it is our duty to help making the latter possible).
3. People have full power only when they can alter existing (power) relations. (...and it is our duty to help making this possible too).
4. X has to have power over Y to affect results. Power thus is a normative advantage...to change the existing unfair health system and to turn it to the people's advantage. (...and it is our duty to help create that advantage as well).
5. Only exercising full power can people freely select among the available and possible solutions (people's empowerment is thus needed).
6. Claims are rather useless if there is no power to have duty bearers enforce their public health duties.
7. A party other than the duty bearers has to have power over the duties in order to make sure most public health duties are enforced.
8. To enforce a duty, the claim holder needs power over the duty bearer.
9. It is not good if the claim holders have no power or control over the enforcement of their health claims.
10. Actually, people can only have a true health claim when they also have the power to claim for it; the power is a necessary ingredient in their claim; ergo, having a claim necessarily involves having (or getting) power.
11. Rights (claim) holders cannot only be passive beneficiaries of the duties of others.
12. People's health rights are recognized as long as the rights holders have power over the duties.

**122**     *ARE CONTEMPORARY AUSTRALIAN INDIGENOUS POLICIES CONDUCIVE TO REMOVING HEALTH INEQUITIES?*

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The health status of Australia's Indigenous people continues to be much worse than the health status of the Australian population as a whole. The discrepancy between the health of Indigenous and non-Indigenous people is much worse in Australia than in other countries with comparable Indigenous minorities (such as New Zealand, USA, and Canada).

In recent years, the Australian government has claimed that these inequities are due to too much emphasis in the past on 'symbolic' issues such as Indigenous rights and the need for an apology for past wrongs. The government has shifted the emphasis to so-called 'practical reconciliation' which concentrates more on ensuring that services are provided to address Indigenous disadvantage. This shift in emphasis has been accompanied by what the government calls a 'new arrangement in Indigenous affairs', which stresses mutual obligation and the mainstreaming of services.

This paper addresses the question of whether the changes in government policy do in fact show any evidence of reducing the discrepancy between the health of Indigenous Australians and their non-Indigenous counterparts. So far, there is little evidence that there has been an improvement. However, it may be argued that the lag effect of recent policies means that it is too early to see such an improvement. The literature on equity in health and the social determinants of health will be used to show that it is doubtful that current policies will have the desired effect.



**150      *PRENATAL SCREENING FOR SUBSTANCE USE IN CANADA***

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**OBJECTIVES:** This descriptive study sought to compare how Canadian prenatal records address two important, modifiable maternal risk behaviors particularly prevalent among Canadian aboriginal women: Tobacco use and alcohol consumption. All Canadian provinces and territories use government-regulated, standardized prenatal records to guide routine prenatal care and collect data for surveillance of perinatal risk factors. Differences in how well their prenatal records screen for maternal tobacco and alcohol use may result in inequities in the identification, treatment and monitoring of prenatal substance use among pregnant women.

**METHODS:** Government prenatal record forms were retrieved from all 13 Canadian provinces and territories for content analysis. All written items relating to maternal tobacco use, exposure to second-hand smoke, and alcohol consumption were extracted from the records and categorized into assessment questions and intervention prompts. Findings were compared across provinces and territories, and evaluated in light of current better-practice recommendations for reducing prenatal smoking and alcohol use.

**RESULTS:** Provinces and territories differed considerably in the number and quality of screening questions and intervention prompts related to maternal substance use on their prenatal record forms. Many of the records failed to incorporate basic evidence-based guidelines for dealing with prenatal tobacco use, such as using multiple response options to enhance disclosure of maternal smoking status and referring pregnant smokers to specialized smoking cessation resources. Prenatal record questions and prompts related to maternal alcohol consumption also revealed uneven integration of better-practice recommendations. Despite the potentially devastating consequences of fetal alcohol exposure, less than half of the prenatal records contained comprehensive screening guides for identifying high-risk prenatal alcohol use patterns (e.g., T-ACE score). More recently-revised prenatal records did not necessarily have better questions or prompts related to maternal substance use, suggesting differential uptake of the available evidence by those at the provincial/territorial level responsible for prenatal record content.

**CONCLUSION:** Simple modifications to Canadian prenatal records may improve population-wide screening and health services delivery for maternal tobacco and alcohol use. Harmonizing prenatal record content across Canadian provinces/territories may be an influential pathway for reducing disparities in perinatal health outcomes related to prenatal substance use. Findings highlight the challenge of developing universal prenatal screening tools that adequately capture different patterns of risk factors underlying health inequities among vulnerable groups. This study led to a funded proposal to examine in-depth how provincial-level policy decisions are made around prenatal record content specifically related to maternal tobacco and alcohol use, in six Canadian provinces.

167 *CAN A SEPARATE PROJECT REDUCE SOCIOECONOMIC DIFFERENCES IN HEALTH - EXPERIENCES FROM THE TEROKA -PROJECT IN FINLAND*

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Finns have become healthier, and the population's life expectancy has increased. However, not all population groups have equally benefited from this trend. Socioeconomic disparities in health and health related lifestyles tend either to have persisted or grown. The life expectancy for a 35-year-old male is six years shorter among manual than upper non-manual workers. The corresponding difference in women is three years. Socioeconomic differences in mortality have increased over the past few decades and are large by international comparison. Reducing socioeconomic differences in health has been a central goal of Finnish health policy for decades, but quite little has been achieved. The most recent national programme, Health 2015, aims to narrow differences in mortality between groups with different educational backgrounds, different vocational groups and the genders by 20% by the year 2015. Health differences between population groups are influenced by a number of factors related to living conditions, working conditions, lifestyles and the functioning of the service system. It is important to include the viewpoint of health distribution in the development and evaluation of health and social welfare interventions and policies.

In Finland a major challenge for health policy is to find the means to promote health equality. The purpose of the TEROKA project (Narrowing socioeconomic health differences in Finland) is to increase awareness of potentials for narrowing health differences and the means of promoting health equality in practice. TEROKA is collating information on the reasons for and trends in socioeconomic health differences, and on means and methods of narrowing these differentials in Finland and other countries. The project is also exploring the potential for cooperating with existing programmes and policies. TEROKA is a joint project run by the National Public Health Institute, STAKES and the Finnish Institute of Occupational Health. The aim is to set up a network of actors where ideas and experiences can be pooled to generate practical measures for narrowing health differences.

The paper will discuss experiences from the three-year TEROKA project. It concludes that there is a need to develop a coherent analysis and a special strategy focusing on the reduction of inequalities in health on the international, national and municipal level in tackling inequalities in health. Finally it discusses the role of project based activities compared to institutionalised health policy mechanisms.

## 81 *Who benefits from an integrated community insurance scheme?*

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Recognizing that poor households face multiple and varied risks, some organizations have begun to provide insurance against multiple risks. For example, micro-finance organizations are increasingly offering both life and health insurance to their members. However, there is no evidence as to the relative benefit of different components of an integrated insurance scheme.

The objective of this study was to assess the distribution of benefits under Vimo SEWA's integrated insurance scheme – which includes health, life and assets components – by: (1) socio-economic status of members, and (2) place of residence (urban-rural).

It was seen that overall the scheme was equity neutral in relation to the distribution of benefits across poor and less poor members. However, on comparison of the data for rural and urban areas, and for different components of the scheme, two main inequities became apparent. The scheme was skewed in favor of urban members, who received a far higher proportion of the benefits compared to rural members. Further, in rural areas, the poorest members were disadvantaged compared to better-off members with regard to hospitalization benefits; under this component, the least-poor decile of rural members received almost four times the benefit received by the poorest decile. The study found that health accounts for more claims and the highest percentage of total benefits, followed by life and then assets. The inequitable benefit ratios for rural versus urban members and for the poorest versus least-poor rural members (for the health insurance component) were primarily due to the many barriers that the poor face in accessing medical care and submitting insurance claims.

Based on these findings, steps that can be taken to make an integrated scheme more equitable include, (1) differential pricing according to place of residence (i.e. higher premiums for urbanites); (2) different rules that make the benefits more accessible for the rural/poor (for example, cover transportation costs as part of the insurance); and (3) making greater efforts at trust-building and education among rural/poor members.

The findings of this study indicate that an integrated community-based insurance scheme can successfully provide risk protection to the poor, and equitably distribute benefits. However, for effective risk protection, it is important that such programs be monitored closely. The design of the insurance product, delivery and service mechanisms and facilitating systems at the macro level are all important for ensuring the equity in such schemes.

214 *Challenges to Research on Equity in Health*

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The ISEqH recognizes that equity in health connotes the absence of systematic and potentially remediable differences in health across population groups characterized socially, geographically, or demographically. Understanding the genesis of inequity in health requires exploration of the pathways by which it occurs and how it is maintained in different societies and over time. Existing frameworks for thinking about pathways are limited by a focus on individual influences on health rather than on societal influences. As equity, by definition, concerns distributions in health across populations, an individual focus is inappropriate. This presentation provides a comparison between the two levels of focus and shows how the societal focus provides a better basis for devising informed approaches to reducing inequity. Challenges that must be overcome include developing standard methods for characterizing influences on health; deciding on appropriate levels of geographic aggregation; elucidating interactions among influences; refining approaches to characterize distributions across population subgroups; and distinguishing effects of influences on the incidence, prevalence, and case-fatality associated with different manifestations of ill health and health. Imperatives for the success of equity research include recognizing that there is no such thing as a determinant of inequity, as the extent and magnitude of influences varies by time, place, and context. Moreover, interactions among influences are characteristic rather than the exception, and the nature of pathways differences across population and population subgroups. Therefore, stratification of analyses by major population subgroups is more important than controlling for the differences across the subgroups

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**1.49 COMMUNITY PRIORITIES & INDIGENOUS RESEARCH FUNDING**

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**BACKGROUND:** Within a research community the grant funding process sets the tenor of the research culture. In most research communities, research is primarily investigator-driven and quality assessment of research proposals is underpinned by the practice of academic peer review. This is a source of contention generally for a number of reasons but it is particularly problematic in Indigenous research. In this project we used an Australian Aboriginal majority-controlled research-funding organization, the Cooperative Research Centre for Aboriginal Research (CRAH) as a case study to look at the processes around research project commissioning and funding.

**METHODS:** This project was guided by a steering group drawn from Aboriginal research sectors and members of the steering group also contributed to the research findings. Interviewees were selected to represent a broad cross-section of stakeholders associated with CRAH. Semi-structured interviews (n=18) were conducted canvassing views on the present system of research funding process and what an alternate process might look like. A discussion document supported by an extensive literature review was provided prior to interview. This was an iterative process where the discussion document and interview schedule were updated as the research findings informed the project.

**FINDINGS:** Existing systems of research commissioning and quality assessment were seen to place excessive demands on the research community and do not necessarily result in research reflecting the wider community's priorities or values. Participants overwhelmingly endorsed a move to a more collaborative culture although the perceptions of the form this culture might take varied. A range of barriers to changing research culture were described. Participants indicated that a collaborative model for research funding process might incorporate:

- Involvement of grant funding body as broker of research proposals with funding support for collaboration between communities, service organizations and academic researchers
- Requirement for continued involvement of the funding organization in the entire research process including research transfer and evaluation
- Capacity building for community involvement in research
- Mentoring of Aboriginal and non-Aboriginal researchers in particular to ensure research transfer processes are set in place
- 'Critical friends' to provide constructive feedback on research projects rather than blinded peer review.

The use of a collaborative structure for targeted project development and evaluation would permit the redistribution of time and effort previously expended on peer review process and would allow increased community participation in decision-making in the research funding process.

## 32 INCOME INEQUALITY AND HEALTH INEQUALITY MEASURES

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**INTRODUCTION:** Findings from studies throughout the world have consistently indicated monotonic relationships (although not necessarily linear) between health and socioeconomic status (SES). Furthermore, these associations have been evidenced at every level of social hierarchy, invariably unfavorable to the less privileged groups, generating the concept of social gradient in health. The objective of this paper is to examine the effects of income inequality on traditional measures of health inequalities based on Brazilian data.

**METHODS:** The mathematical relationship between income and the health outcome was simulated as a monotonic function with a non-constant gradient, steeper at low-income levels than at high income levels. The simulation was based on Brazilian data, considering the infant mortality rate as the response variable. Using the same mathematical model, traditional health inequality measures (like the rate ratio, the slope index of inequality, the dissimilarity index, the population attributable risk and the concentration index) were calculated for different income aggregation groups. To examine the effects of the inequality in the income distribution, two simulated lognormal income populations with the same mean but different variances were used.

**RESULTS:** The different ways of aggregating income under the supposition of a non-constant decreasing rate affect all the health inequality measures. Estimates of the magnitude of social gradient are significantly affected when income is classified on the basis of quintiles or deciles. Further, differences in the variances of the income distribution affect measures that are based only on the ordered nature of income. In particular, the concentration index, which does not take into account the variance of income, is extremely affected. In the case of Brazil, the extreme poverty concentration influences geographic and time comparisons of infant mortality inequalities.

**CONCLUSIONS:** While there has been an important growth in methodological procedures to measure the magnitude of the inequality in health, it is important to establish to what extent these measures are capable to identify the contribution of the health system in decreasing health differences. The results indicate that the most traditional indexes are affected by the inequality in the income distribution. Therefore, poverty concentration and disparities on income distribution cannot be neglected when quantifying the impact of interventions on health problems from which the poor suffer disproportionately.

**139**     *SOCIAL DETERMINANTS OF SMOKING IN INDIGENOUS AUSTRALIANS*

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We will describe the social determinants of smoking in Aboriginal and Torres Strait Islander people. We will compare the distribution of these determinants in non-smokers and smokers, and more importantly in ex-smokers and ever-smokers, and never-smokers and ever-smokers.

Smoking is an important pathway to much poorer health outcomes for Indigenous than other Australians. Indigenous peoples are twice as likely as other Australians to smoke and to die from a tobacco-related cause. Smoking has been estimated to cause 10-20% of Indigenous deaths.

The Australian Bureau of Statistics' National Aboriginal and Torres Strait Islander Social Survey interviewed a nationally representative sample of 9,400 adults aged 15 years and over from August 2002 to April 2003. All participants were asked whether they were smokers, ex-smokers or had never smoked tobacco. They were also asked many other questions about their social circumstances, including questions about education, employment, income, financial stress, housing, self-reported health, contact with the criminal justice system, access to transport, and use of information technology. They also answered questions about their family and cultural life: about the use of Indigenous languages, the presence of stressors and support, whether they had been removed from their natural family, and their involvement in social, sporting and cultural activities. We will describe the association of these social factors with not smoking; in particular, their association with quitting and not starting smoking.

More than half (51.2%) the Indigenous population were current smokers. A third (33.4%) had never smoked and 15.4% were ex-smokers, thus 23.1% of those who had ever smoked had now quit. Different social factors were associated with quitting and never smoking. We will describe the age- and sex-adjusted odds ratios of being a non-smoker, never-smoker or ex-smoker for the different social factors. Generally, those Indigenous people in the most disadvantaged circumstances are most likely to smoke, and were least likely to have given up or to have never started to smoke. Finally we will describe three multivariate models (for non-smoking, never smoking, and quitting smoking) that adjust for the combined effect of the different social factors.

Indigenous smoking control programs have the potential to reduce the health inequities between Aboriginal and Torres Strait Islander peoples and other Australians. This better understanding of the clear social patterning of Indigenous smoking needs to be acknowledged and used by tobacco control programs.

21 *Sampling Method: Lot Quality Assurance Sampling Detected pocket areas in MCH Program in Indonesia*

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**ABSTRACT:** The National health development in Indonesia has many programs with formulation of vision "Healthy Indonesia by 2010". One of Indonesian health programs is increasing welfare and health of mother and child. The program is related with one's of the MDG objectives. To achieve vision in 2010 Indonesian should be accelerated the program until in catchments area. Therefore they need a method for catchments area and quick survey, and also could be shown disparity the output program in catchments areas. Plan-Nepal (2000) had developed LQAS a method survey into simple package and had trailed into developed and development country. Ministry of health and Family welfare of Indonesia collaborated with faculty of Public Health University of Indonesia funded by World Bank in 2003 had studied to learned of implemented LQAS to monitor and evaluation of maternal and child health program.

**METHODS:** The Objective of this study is test the applicability of lot quality assurance sampling (LQAS) for the rapid assessment of the performance on mother and child health program. The unit samples in this study were mother, which are having baby with age at least 1 month. Trial surveys were conducted in Cilacap district (west java province) and Jombang district (east java province), which it have an average 30 supervision area (lots).

**RESULTS:** LQAS does not yield specific coverage estimates for lot, but it does identify which lot has acceptable levels of coverage versus those that are performing below expectation. In this study, we found a pocket area (lot) among the areas (lots) that mostly lots have a good performance, which could not detected by National Household Survey or Rapid Survey. However in a district we could get coverage estimates with narrow of confidence interval.

**CONCLUSIONS:** LQAS could be as a part of supportive supervision to assess MCH program and also it could be identify small pocket coverage in units (lots). In continuity process, it could be monitoring capacity of provider at program unit and community-based and also decision-making. But in LQAS method, we should more pay attention with the parameter coverage we need to be set before the sampling begin. The level parameter coverage that would be deemed "unacceptable" needs to be determined and defined.

**Keywords:** Mother and child program; coverage; LQAS, Health care; Sampling studies; Health surveys; Confidence intervals; Monitoring and Evaluation program; Cilacap, Jombang



87 *Empowerment and Indigenous social and emotional health: the Apunipima model*

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**PURPOSE:**

In Australia, relative powerlessness resulting from colonization and associated public policies has long been recognized as a critical factor influencing Indigenous health and wellbeing. Internationally, the issue of control, or the ability to deal with day to day stresses and associated challenges of life without feeling overwhelmed by them, has been identified as a key social determinant of health. Yet, it is hard to find research interventions that seek explicitly to empower individuals and groups take greater control of the factors affecting their life. This is a complex and challenging aspect of population health where conventional disease focused paradigms of intervention have proven, largely, ineffectual. Clearly, alternate, innovative and creative approaches are required.

This paper will present the findings to date of a North Queensland research program which is evaluating the role and usefulness of empowerment and control as analytical constructs in helping to better understand and address the social determinants of Indigenous health and wellbeing.

**METHODS:**

In partnership with Aboriginal community organizations, James Cook University and the University of Queensland have piloted the Family Wellbeing empowerment course in a wide variety of north Queensland Indigenous settings over the last five years. The research method has involved a combination of participant observation, workshop questionnaires and in-depth interviews.

**RESULTS:**

Research participants have consistently shown evidence of high levels of personal empowerment, including enhanced sense of self-worth, resilience, ability to reflect on root causes of problems and capacity to achieve healthy behavior change. This in turn leads to greater capacity to address structural issues within the wider community such as poor school attendance rates, the critical housing shortage, endemic family violence, alcohol and drug misuse, high levels of chronic disease, over representation of Indigenous men in the criminal justice system and improved access to health services for men. The paper highlights the possibilities and limits of empowerment and control as analytical tools in addressing the social determinants of Indigenous health and wellbeing.

**31**      *Public policies and the process of modernization in the fields of health and education of the Aymara people of Chile in the last 5 years\**

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This opportunity will be used to share the results of the project entitled, "Public policies and the process of modernization in the fields of health and education of the Aymara people of Chile in the last 5 years". The problem looked at in this project is: the understanding of the repercussions that modernization has through public policies on the fields related to health and education, in the Aymara Chilean Community since the appearance of the indigenous law; considering in the process, the analysis of the socio-cultural appropriateness of these policies on the re-ethnification process and identity of the Aymara people.

It is known that communication difficulties limit the efficiency of public policies in the educational and sanitary fields, especially as the result of a lack of inserting the contents of such policies in the target culture.

Direct and indirect evidence indicate that the Aymara ethnic group of Northern Chile could see themselves affected by the modernization of the healthcare and educational sectors. Our objective is to find out if this impact is positive, negative, or innocuous in the cultural re-ethnification process of the Aymara people.

The resistance to activities and guidance could be seen elaborated in a work of intercultural communication that has a deep analysis of the imagined, ethnically-enclosed collective as a pre-condition.

This project, as a descriptive vision, will bring quantitative and qualitative indicators that will be useful in framing community work with communicative guidelines in agreement with Aymara culture. Its methodology pursues the combination of Thick Description or Grounded Theory of communication inward and outward from the Aymara ethnic group with the measurement of the impact of assimilation of sanitary and educational guidelines of this human group.

The project attempts to generate a descriptive evaluation as is public policy for the government of Chile and directed at the original groups of the country. It will focus on the special features that are presented in those initiatives that are framed by intercultural health and education of the Aymara people of the first region of the country.

To succeed in reaching some sustainable scientific understanding and in terms of methodology, an intervention strategy that allows us to collect categorical data is being proposed, which means creating a deep vertical cut in the phenomenon of the study, which discloses the categories from the interviewee on the contrary from those of the interviewer.

**56**      *Local Innovations for Health Governance: Health Equity Reform in the Philippines*

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Equity in health is a global concern and is particularly relevant in the Philippines, where many Filipinos who live in rural and isolated areas receive fewer and lower quality health services. According the United Nations, only 50% of those living in rural areas have access to adequate sanitation which also affects health status.

In 1999, the Philippine Government launched the Health Sector Reform Agenda (HSRA) and introduced major organizational and policy changes and public investments to improve the way health care was delivered, regulated and financed. However, gaps in the health system continue to deprive the poor of their right to health.

Inequity in access is not only due to the scarcity of resources but also on the technical and allocative inefficiencies by which health services are delivered. Any appreciation of health equity must therefore consider the various dimensions of access to health such as capacity to pay for and spatial access to health care facilities and services.

It is in this context that the project on “Partnerships for Health Planning: Strengthening Local Capacity for Health Equity Reform (HER) in the Philippines “ was initiated by the Canadian Society for International Health in partnership with a local organization, the Gerry Roxas Foundation. Funded by CIDA, the project was piloted in one Inter-local Health Zone (4 municipalities) in the Province Capiz.

The HER project was an attempt to ensure that the ongoing health reform process in Capiz would consider both the equity and efficiency concerns of health planning. It sought to make health personnel conscious in using an “equity lens” as a tool to make decisions to allocate resources equitably. Started in March 2003 and completed in October 2005, the HER project addressed a significant policy gap in terms of supporting local health planning, especially at the barangay (village) and municipal levels.

The HER project aimed to strengthen local capacity for resource allocation decision-making to ensure equitable health services planning at the decentralized levels. Concepts of equity were used to identify the determinants of health as a basis for budget allocation and planning. Using a participatory approach, planners are now able to analyze and use relevant data to determine priority health problems and interventions that considered the community’s actual needs and preferences. “Negotiation” workshops for resource allocation allowed community leaders the opportunity to commit resources for specific interventions and lobby local chief executives for budget allocations responsive to health related concerns.

**242**     *The Importance of Knowledge Translation in Indigenous Health Research and Policy Development*

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The health disparities faced by North America's Indigenous peoples are well-known to the research and policy community. The gap between the health status of Indigenous people and non-Indigenous people has been the subject of much research, policy development, and collaboration, aimed at improving the health status of Indigenous people. As a result, the health of Aboriginal people in Canada, American Indians, and Alaska Natives is starting to improve, although there is still a great deal of progress to be made.

Discovering pathways to better health for Indigenous peoples is multi-faceted. Not only does this involve targeting the determinants of health, lowering chronic diseases, improving access to health care services and implementing effective health promotion; it also involves incorporating Indigenous knowledge into efforts in these areas. Indigenous culture, values, and traditions regarding health must play a prominent role in health research and policy development, in order for research and policy to be effective and relevant to Indigenous peoples.

Also fundamental to improving the health of Indigenous people is ensuring that research and knowledge generated reaches Indigenous people in a format that is appropriate. Knowledge Translation is the essential tool for ensuring that this happens. Commonly defined as: the way that information is taken up and shaped by users, knowledge translation strives to make health research more useful to researchers, policy makers, health practitioners and the public.

In the field of Indigenous health, knowledge translation has an especially important role to play. It is the means by which researchers, policy makers, and Indigenous people can come together and share ideas regarding Indigenous health. Knowledge translation is a tool that policy makers and researchers can use to bridge the gap between western science and Indigenous knowledge, in a way that is respectful, meaningful, and relevant.

This presentation will discuss the importance of knowledge translation in the field of Indigenous health research and policy development. This will include discussion of Indigenous and western knowledge, defining knowledge translation, the differentiation between content and process in knowledge translation, and the impacts of effective knowledge translation in the field of Aboriginal health research and policy development. The presentation will also include several case studies of successful knowledge translation initiatives in Canada. These case studies will highlight the effectiveness of innovation, integration, and adaptation in successfully conducting knowledge translation initiatives. Finally, the presentation will discuss some of the key challenges inherent in knowledge translation, and will provide participants with the opportunity to discuss strategies to conquer these challenges in their respective fields.

172 *Study on Evaluation of the Fairness of the Effects of Rural Health Insurance Program in Yunnan, China*

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**PURPOSE:** The purpose of this study is to use benchmarks of fairness approach (Daniels 2000, 2005) to assess equity, efficiency and accountability of the implementation of the New Rural Cooperative Medical Scheme (NRCMS) in minority areas of Yunnan, China and to inform policy-makers about the results of using the tool in order to improve deliberation about rural health care reform and equitable healthcare for ethnic minorities.

**METHODOLOGY:** Adapting the generic benchmarking criteria to assess the goals and outcomes of the NRCMS. (1) Collecting evidence about the expected effects of the implementation of the NRCMS on indicators; (2) refining the generic benchmarking criteria and specifying indicators appropriate to local conditions; (3) making a pilot effort at evaluating implementation of the NRCMS by using the evidence-based indicators within 1 minority county of Yunnan province.

**MAIN POINTS:** (1) The NRCMS initiated and supported by Chinese government for providing a cooperative health insurance scheme for rural populations needs to be evaluated and monitored in order to achieve the scheme's aim toward improving rural health delivery and rural populations' health level; (2) the benchmarking methodology offers an evidence-based approach to evaluating and monitoring the implementation of the NRCMS by adapting benchmarks to local conditions and specific goals; (3) developed evidence-based indicators are used to evaluate and improve the implementation of the NRCMS at aspects of equity, involving financing, having access to health care, benefit for rural population enrolling the NRCMS; efficiency, including improving rural health services and strengthening rural medical staff's capacity; accountability, concerning democratic and public surveillance on performance of the NRCMS.

**CONCLUSION:** Results of this study piloting within 1 minority county of Yunnan, a province with diversity of ethnic groups, can be applied to other counties of the province for conducting ongoing monitoring and evaluation of the performance of the NRCMS when the initiative will be phased in over next 3 years across the province. The study by using evidence-based indicators to evaluate and monitor the effects of the NRCMS provides an approach for policy developers to improve deliberation about rural health care reform and equitable healthcare for rural populations. Investigators' capacity building of research on health policy and systems goes along with this study, which will contribute to research and practice of creating health and enhancing equity in health.

**194**     *Improving Equity in Gene Patenting for Indigenous Peoples*

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This paper examines some of the inequities in gene patenting, particularly for Indigenous peoples. It makes suggestions as to how to reduce the inequality, exclusion and poverty that existing patent laws create. The paper adopts a political economy stance. It highlights the distortion that has arisen in the way that patents are now being used as compared with their original theoretical intent to increase the likely return on investing in otherwise high risk research.

The paper begins by describing how gene patenting laws currently operate. It examines how these laws, supported by international trade regulations, raise a number of threats: to world food security, to access to medicines and to Indigenous property rights, thereby exacerbating the general divide between the rich and poor.

The paper briefly outlines the history of gene patent laws, their purpose and whose interests the laws serve. It draws on examples of Indigenous knowledge and third world genetic diversity which are being exploited by corporations based in the developed world, particularly in pharmaceuticals and food products.

The role of patents is analysed in a structural context i.e. within an analysis based in global political economy and in a critique of neo-liberalism. Gene patenting, it is argued, is a further extension of corporate capitalism.

The paper argues that, while most genetic diversity is located in developing countries, as a result of patenting regimes and international trade agreements, the flow of capital from this resource is to the developed world.

The author concludes with suggestions that while no single nation state can hope to regulate transnational corporations' activities on its own, by developing local sui generis (unique) legal regimes, Indigenous communities can build the potential to control the ownership and benefits which flow from Indigenous community knowledge about particular bio-diverse medicines and foods. Examples of where this both has and has not occurred will be given.

45 *DOTS in China - Removing barriers or moving barriers?*

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**BACKGROUND:** Tuberculosis (TB) is a disease closely related to poverty. In China, the prevalence of TB in the poor rural areas was higher than that in cities (397/100000 vs.198/100000), and the mortality of TB was three times higher in rural. To improve equity in access to TB diagnosis and treatment for the poor rural people, to control TB epidemic, in 1992 a revised National TB Control Programme (NTP) with the directly observed treatment, short course (DOTS) was implemented in some province of rural China. The key motives for the revised NTP were to reduce financial barriers to patients by removing fee charges for diagnosis and treatment and to address regressive suppliers' incentives for appropriate referrals.

**METHODS:** One county with subsidized NTP-DOTS project - Jianhu and one county without - Funing, were selected. A cohort of 493 newly diagnosed tuberculosis patients during 2002 was studied. Patient's expenditure, demographic and socio-economic data were collected. During the follow-up period, Funing County started implementing NTP-DOTS, which offered a dual design of cross-sectional and longitudinal comparison.

**RESULTS:** Ninety-four percent (465/493) of subjects were followed-up. The average income of the patients was only 1450Yuan/year. 93% of the patients had no any kind of medical insurance. The mean total patient's expenditure on TB medical care and transportation/accommodation before TB diagnosis was higher in Jianhu than in Funing (715 vs. 256Yuan). Patients spent 715Yuan in general hospital before they were referred to TB dispensary for the subsidised TB treatment. After obtaining TB diagnosis, patient's expenditure was higher in Funing than in Jianhu (835 vs. 157Yuan). After implementing the NTP-DOTS in the late stage of the study in Funing, patient's expenditure after diagnosis decreased slightly to 508Yuan, whereas expenditure before diagnosis increase significantly to 451Yuan.

**INTERPRETATION:** Our results indicate that partial reform in the context of a market-based health system is problematic. A vertical pro-poor project could not reach the poor if it is embedded in a marketizational health system. Doctors could adapt to new incentive structures and find new ways of keeping revenue at the old levels. TB patients suffer a heavy economic burden no matter in counties with or without subsidized TB care. The total patient expenditure was not reduced, but shifted from after diagnosis to before diagnosis. The shift could imply delays in diagnosis and treatment with an increased risk of infection transmission.

187 *The distribution of burnout and its correlates among paid employees in Taiwan*

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**OBJECTIVE:** The aim of this study was to investigate the prevalence and the distribution of burnout by demographic characteristics and working conditions in a nationally representative sample of paid employees in Taiwan.

**METHODS:** A national survey was conducted in 2004, consisting of 8906 male and 6382 female employees aged between 25 and 65 years. Information on demographic characteristics, working conditions and health status were obtained by a self-administered questionnaire, including educational level, employment grade, working hours, psychological job demands, job control, family care workloads, and the status of personal burnout and work-related burnout as measured by the Chinese version of Copenhagen Burnout Inventory (C-CBI).

**RESULTS:** Long working hours were common among Taiwanese paid employees—12.7% of men and 9.1% of women reported having worked for 49 hours or longer in the week prior to the survey. Younger employees had higher levels of personal burnout and work-related burnout than older employees in both genders. Women were found to have higher levels of personal burnout and work-related burnout than men across all age groups and employment grades. When stratified by gender and employment grade, women who were better educated and with higher employment grades were found to have higher levels of burnout than women in lower socioeconomic categories. However, there was no apparent social pattern of burnout across socioeconomic categories in men. In both men and women, employees who were younger, working for longer hours ( $\geq 49$  hours last week), having higher job demands, and having either young children (aged  $<6$  years) or disabled elderly at home were found to have higher levels of burnout.

**CONCLUSION:** This study identified high-risk groups of burnout in the general working population in Taiwan. We suggest the identified groups should be targeted for intervention and prevention of burnout problems. Further work will be needed to establish the trends of burnout, to determine its social determinants, and to develop avenues to reduce stress and stress-related health problems in the workplace.



190 *Work and health of nursing aides in Taiwan*

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In Taiwan, it is a common practice that a hospitalized patient has to be accompanied by a family member during his/her stay in hospital. While the population is aging rapidly and the traditional role of female family members has been changing, nursing aides have become important substitutes for family members to carry out care work in hospital. Additionally, while many hospitals are under tremendous pressures to contain cost, nursing aides also become important substitutes for registered nurses. Nursing aides are often primary caregivers and having far more contact with patients than family members or hospital staff, thus their health status and work conditions should be important considerations for health care quality.

However, nursing aides in Taiwan are characterized with low in entry qualification, long working hours, low pay, high in physical and emotional demands, and lack of career prospects. Additionally, most nursing aides get their jobs through the introduction of commercial manpower brokers. Because they are outsourcing workers, nursing aides don't possess equal protections by labor laws as regular employees. Furthermore, hospitals' safety precaution measures are often not equally applicable to this work group. In 2003 when Taiwan was struck by the devastating outbreak of Severe Acute Respiratory Syndrome (SARS), several nursing aides were infected in hospitals and finally died. Several nursing aides were suspected to contact infected patients and disseminate the epidemic when they worked in hospitals. The role of nursing aides quickly drew public's attention. However, most discussions concern with patients' safety and quality of care. There has been little consideration from workers' perspectives, especially their work conditions, occupational hazards, as well as work and health well being.

In this study, we adopt multiple qualitative methods, including case study to find out peculiar features in the work of nursing aides, policy analysis to understand regulations or protection measures concerning their occupational safety and health, and in-depth interviews with nursing aides to find out their own perspectives concerning work hazards and health. Findings of this study show that nursing aides in Taiwan were concerned with financial difficulties, emotional strain from stressful and unpleasant work duties, monotonous work, long working hours, separation from their families, potential for sexual harassment, musculoskeletal discomforts, risk of infecting diseases, and lack of organizational support at work. More support should be provided for nursing aides, not only to protect their health at work, but also to safeguard patients' safety and improve health care quality.

**119**     *LOCATION ON HEALTH, SOCIAL CAPITAL & EQUITY IN ADELAIDE*

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This paper draws on data from a study, conducted between 2004-06, in four Adelaide postcode areas with contrasting socio-economic levels that explored the links between health and a range of neighbourhood characteristics including levels of bonding, bridging and linking social capital.

Two of the postcodes are rated as having relatively high socio-economic status and two as having lower than average socio-economic status. The data presented will be based on three sources: a postal survey (n= 3432) that collected data on self-reported health status, social capital (networks (including bonding, bridging and linking ties, cohesion, trust, reciprocity and help available) and perceptions of a range of neighbourhood characteristics; 80 in-depth interviews which explored these issues in more detail; and a survey of community groups within the study areas.

The paper will present data relating to the differing levels of social capital in the suburbs and the links between these and self-reported health status. The following findings will be explored in this paper:

- The differences in self reported mental and physical health status between the suburbs
- The existence of higher levels of the range of social capital measures in the higher socio-economic status suburbs
- The differences between the two lower socio-economic suburbs whereby one consistently scores higher on social capital and health measures
- The relationship between measures of social capital and health status compared between the suburbs
- Analysis of the ways in which social capital may contribute to health inequity

The paper will draw on the interpretation of social capital by Bourdieu in terms of his view of social capital as one of the mechanisms by which class privilege is maintained and reproduced. Our findings will explore whether social capital acts to reinforce the existing privilege of individual households and the extent to which this will contribute to a neighbourhood environment that is more trusting, co-operative and reciprocal and networked to persons of influence. The paper will conclude with a discussion of the implications of these findings for policies designed to reduce inequities in health status.