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Tackling Health Inequalities: what senior managers think

J Hyde

Abstract

Objective: To describe how New South Wales (NSW) Area Health Service Chief Executive Officers (CEOs) understood concepts of equity in the development of NSW Health's Equity Statement; CEO knowledge and interpretation of a given concept being one aspect of developing policy.

Design and Setting: This paper describes the process through which NSW Area Health Service CEOs were involved in developing the Equity Statement, specifically:
1. Briefings with individual CEOs on key issues and identification of possible difficulties and potential ‘equity champions’.
2. A two-hour workshop to explore (‘pre-mortem’) why the proposed statement might fail.
3. CEO involvement in identifying strategies that promoted equity already operating locally.
4. Consultations with selected individuals about the draft recommendations.
5. Feedback to CEOs.

The article provides a case study of consultative policy making by illustrating how participant knowledge can both inform and be strengthened by involvement in the policy development process.

Results: There was a high level of awareness among CEOs of health inequalities and an acceptance of their responsibility to address them. They saw three main ways of doing this: a) equity of resource allocation for health service delivery within and between regions; b) equity of access to health services based on need; and c) equity of health outcomes. CEOs felt that making the health system accountable for health outcomes would provide pressure for system-wide resource allocation changes. They recognised that factors substantially impacting on health outcomes were outside the control of the health system. Furthermore, finding a balance to which they could be held accountable was difficult. All CEOs saw ensuring needs-based access to services as a key area where they could potentially have an impact; and they specifically saw challenges in a conflict between equity and efficiency, marginalisation of special treatment for disadvantaged people, balancing investment in rescue services and prevention/early intervention, and developing a rational health financing system. The resulting policy has been broadly embedded within the NSW health system with strong local support.

Conclusion: The NSW Health and Equity policy was embedded because CEO leadership and acceptance of the policy enhanced local ownership.

Introduction

A major success factor for interventions by health systems that address the issue of equity is the commitment of leaders. [1] This paper describes how NSW Area Health Service (AHS) Chief Executive Officers (CEOs) understood concepts of equity in the development of the NSW Health and Equity Statement. The paper concentrates on CEO input into the process of policy development through the personal interview process. [2] CEOs were participants in the project, which was conducted between July 2000 and September
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2001, and informed and led some of its development. Consultation workshops with AHS CEOs, and other external stakeholders in metropolitan and regional locations supported the process, which also involved targeted CEO interviews.

This study of CEO engagement in the policy development process has resonance for places other than NSW and provides a case study of consultative policy making. While the paper considers matters regarding policy formation, readers can learn more about equity and health from the following references. [3,4,5,6,7,8]

When NSW Health decided to develop a health and equity statement, the importance of engaging the CEOs was recognised as key to the successful implementation of the outcome. At the time NSW had seventeen AHSs and three other Health Services (NSW Corrections Health, the NSW Ambulance Service and the Children's Hospital, Westmead), funded according to a weighted population formula known as the NSW Resource Distribution Formula (RDF) [9] – with weightings for socio-economic status, age, Aboriginality and rurality. Equity was a key concept in the development of AHSSs, though not always understood in its wider sense. The NSW RDF included some aspects of equity from a global perspective but no concept of internal equity at the local or intra-Area level. Equity was generally seen in terms of access to services; often hospital services. However other aspects of equity – equity of health outcomes and equity in health financing – were less evident in the rhetoric of health.

NSW Health is part of a larger cluster of human services departments with a central Human Services CEO Forum to promote collaboration that is replicated (sometimes with additional members like NSW Police) at a regional level. From 1995-2000 NSW Health released a number of equity-based health policies in primary and community health, mental health and Aboriginal health. In Public Health a new understanding that health promotion included capacity building as a core concept, was introduced. [10] These developments culminated in 2000 when the NSW Health Department commissioned the Centre for Health Equity Training, Research and Evaluation and the University of Western Sydney to develop a Health and Equity Statement. This represented a significant investment by NSW Health in a broad and inclusive process to promote an understanding of equity in the system and to bring together key stakeholders to ensure long-term acceptance and sustainability of the Statement.

Figure 1: Project Development Flow Chart – the five stages of engagement, 2000-2001

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Note: AHS CEOs – Area Health Service Chief Executive Officers
Method
A case study approach was used involving five stages of consultation and data collection (Figure 1). The first action was the appointment of the Project Team.

1. Project Team
The Project Team had extensive experience in health and a broad understanding of equity and was supported by a Project Management Committee and two Reference Groups. To demonstrate commitment at the highest system level, the Director-General of NSW Health chaired the Project Management Committee. Two Reference Groups were formed to provide advice and support to the Project Team – the first comprised external stakeholders in Health Services including two AHS CEOs; and the second comprised internal NSW Health Department stakeholders. Six key focus areas were identified by these groups: strong beginnings; increased participation; a focus on place; old problems, new solutions; organisational development; and budget and resource allocation.

Technical working groups were convened to address each of the first five focus areas. Three AHS CEOs were members. The sixth focus area was added following the first round of CEO consultations and remained the responsibility of the Project Management Committee. A targeted literature review was commissioned. [11]

2. Interviews with Area Health Service Chief Executive Officers
As indicated in Figure 1, Stage 1 of the project involved interviews with AHS CEOs. One interviewer conducted all initial interviews to ensure consistency. We aimed for the early engagement of CEOs so they could: influence the direction of the project; and have an opportunity to inform the Project Team of local examples of equity-focused programs, projects and interventions including projects that tackled the social determinants of health and health inequalities. The early engagement of CEOs in the study provided the Team with a chance to gauge CEO understanding of and commitment to equity so the Equity Statement could be tailored as an educational as well as operational document. In addition, the early engagement of CEOs enabled the Team to identify potential ‘equity champions’ and existing equity programs/projects sponsored by AHS CEOs; recognition of which should facilitate acceptance of the final policy statement.

Interview questions
One CEO was interviewed in an unstructured format from which issues were identified and a structured set of eight interview questions was prepared. This paper reports the findings arising from the following two questions:
• What do you think are the most important components of equity in the context of the health system and AHS?
• What do you think are the most important links between health inequalities, health status and outcomes and equity?

These first two questions were selected for this paper because they provide the best indication of how CEOs understood and related to equity as a major issue for the health system and for their AHS, and how the policy process was informed. The other six questions are not addressed in this paper because they were more operational and support focused and were not considered relevant to CEO understanding of concepts of equity which is the main focus of this paper. For example, they provided the Project Team with a better understanding of existing interventions, areas of need, gaps in services, possible barriers and other factors required for the development of the final Statement and associated strategies to be achievable and meaningful for the health system.

Interview process and data analysis
Twelve of 20 (60%) CEOs took part in structured interviews of approximately one hour with questions provided prior to the interview. A written record of the interview was sent to participating CEOs within twenty-four hours for them to review.

The Project Team analysed the information, de-identified and consolidated it and circulated a discussion paper to the Senior Executive Forum and later to all staff and stakeholders in the broader consultation process.

3. Workshops to explore potential barriers to success
Stage 2 involved a two-hour workshop (known as the ‘pre-mortem’ workshop). This workshop involved 17 of the 20 (85%) AHS CEOs plus members of the Senior Executive Forum and other Human Services CEOs. Participants were asked to assume the Equity Statement had been released three years previously and that its implementation had not been successful. Key equity issues were presented, small group discussions identified issues likely to be associated with implementation-failure and ways that successful implementation could be encouraged. Analysis of the information arising from this workshop was included in the draft Equity Statement and Strategies documents.
4. Identification of AHS strategies so CEOs could identify opportunities to build on them
During Stage 3, all CEOs identified the senior AHS officer working on local equity initiatives who could provide details of initiatives; these became the basis of the Equity Strategies document.

5. Individual consultations on draft recommendations to identify levels of support for the strategies and possible implementation problems
The draft Equity Statement and Equity Strategies documents were circulated for feedback to all twenty CEOs during Stage 4 so they could review how their input was used in the development of these documents. Importantly, it was also used to reinforce the partnership approach between the Project Team and CEOs, thus cementing the relationship and strengthening the commitment of identified champions to the policy statement.

6. Feedback on CEOs’ concerns being taken up in the final document
Stage 5 of the project involved a further series of unstructured interviews with 15 (75%) CEOs. These interviews were organised during Stage 4 and were carried out by different members of the Project Team working in pairs. CEOs were invited to consult more broadly with their senior staff to elicit comment on the draft Equity Statement and Strategies. The aim of the feedback was to ensure CEOs that their input had contributed to the final Report and thus to cement their support.

Findings
CEO understanding of the concept of equity
Initially, CEO understanding of the concept of equity was varied though most appeared to have an implicit understanding of the key concepts even if unable to articulate them. Among participating CEOs there was a high level of awareness of health inequalities in NSW. All participants accepted they had at least pockets of disadvantage within their AHS and accepted responsibility to address them in three main ways:
1. Equity of resource allocation for service delivery within and between regions;
2. Equity of needs-based access to services; and
3. Equity of health outcomes.

There was good understanding of the distinction between equity of access and of health status and outcomes, and the close relationship between equity and health financing in an operational context.

Over the course of the project CEO responses showed that their understanding of the concept of equity had changed as a result of their involvement. In addition, their responses informed the way the policy was developed and framed.

Question 1: Most important components of equity
CEOs identified three important issues: access, health outcomes and health financing.

1. Access. The importance given to socio-economic status and Aboriginality reflected the growing debate about health inequalities, and in Australia, the appalling health status of the Indigenous community. None equated equity of access with a right to services on demand - equity of access meant the ability to access services on need. Issues raised included rationing some publicly provided services (or moving away from universal provision); concentrating on specialist services focused in the areas of most need; concern at the removal from the Australian Health Care Agreement of an obligation for services to be available on the basis of medical need; and ‘market forces’ in health or US style ‘managed care’ seen as restricting access. There was not agreement about such changes.

2. Health Outcomes. All participants recognised that most issues affecting health outcomes are outside the control of the health system, and that the system must become more proactive in orienting general health services toward equity outcomes. Eight of 12 CEOs (67%) recognised health outcomes as the most important aspect of equity in health care and that other equity considerations should flow from an outcomes analysis. There was concern at their ability to maintain balance, especially when faced with increasing demand for highly specialised and expensive technologies in acute care, when improved health outcomes are contingent on achieving equity of access to a broader range of health services in community health and primary health care. Ten of 12 CEOs (83%) believed that extremes in health outcomes and access should be the benchmarks that determined the interventions developed by the health system to provide enhanced services for those outside acceptable health outcomes bands, suggesting that the “inverse care law” was implicitly recognised. As one CEO said: ‘Getting the service delivery structure appropriate to the local community is the most important component in achieving equity’.

3. Health Financing. Two factors drew general agreement from participants: a) outcomes equity should drive making resource allocation decisions (8/12 = 67%); and b) expenditure is too high at the high end of acute care where...
we are ‘tweaking’ without gaining much in improvement in health outcomes (7/12 = 58%). The NSW RDF was seen as valuable for achieving equity of resource allocation on a population basis but most CEOs believed it had reached the limits of its effectiveness. Suggested enhancements to the NSW RDF included: a) refining the formula to include more targeted factors such as those with an equity outcomes focus (like remote and Aboriginal health); b) developing resource allocation strategies at AHS level to ensure the state level population focus of the NSW RDF is reinforced by better local targeting; and c) linking resource allocation and quality especially where quality is linked with improvements in health outcomes. There was also strong support for the pooling of resources and for better coordination and planning between all tiers of government to achieve equity of health outcomes. One CEO suggested that:

In addressing these issues the system must take a more sophisticated funding and resource approach. Growth funds should not be used for reversal of [inter service] flows and similar maintenance of the system issues but should be used for growth. Similarly fund holding is important and useful but must be transparent. This will allow for equity investment especially in managing a balance between growth, flows and latent demand that appears as new services are developed.

Other issues raised included developing a more sophisticated approach to resource allocation to ensure that equity investments are managed in a manner that achieves a balance between growth, flows of services and consumers across AHS, support for state-wide highly specialised services, and latent demand that emerges with growth.

**Question 2: Most important links between health inequalities, health status and outcomes and equity**

All participating CEOs recognised a direct link between health inequalities and equity. In tackling that link, funding and resource allocation were seen to be crucial. Suggestions included: a) changing the balance in funding decisions toward primary health and early intervention; b) resource movement is more easily achieved at an AHS level with a state level mandate for change; and c) addressing the balance of resources for remote communities in addition to other factors in the RDF.

Four issues emerged during discussions with CEOs that should inform moves toward an equity-focussed system:

1. **Socio-economic status.** Ten of 12 CEOs (83%) noted that social and environmental outcomes flow from income levels and employment, and by the end of the consultation process there was an understanding by all that universal services underpin targeted services that aim to achieve equity. They recognised a need to link clinical conditions with social factors, with funding based on both pre-treatment/intervention, health status and post intervention health outcomes. Three CEOs (25%) rated intervention education as high as income.

2. **Indigenous health.** Economic, education, housing and public infrastructure were considered to be key issues, particularly in remote communities and especially in Aboriginal communities. Generally CEOs believed the broad picture was well developed but the crisis of demand and a lack of flexibility in funding meant the local level was unable to move away from ‘rescue’ services to prevention and early intervention. Seven of 12 CEOs (58%) saw Indigenous health as the key equity indicator.

3. **Quality.** Four CEOs (33%), especially those with large tertiary teaching hospitals, noted the failure of quality and safety to engage the private health sector, which was seen as being important in terms of equity of health outcomes.

4. **Investment.** Resource allocation and investment decisions were perceived to be a significant issue. Nine of 12 CEOs (75%) were concerned that investments had not been thought through adequately. Five (42%) were concerned that equity and efficiency were not compatible. [12] CEOs believed that investment in equity-focused interventions must be transparent and linked to improvements in health outcomes. This finding reflected CEO concern with ‘tweaking’ policy decisions directed toward the high cost acute care sector rather than broad prevention and early intervention strategies. Similarly, CEOs perceived that investments from growth funding must be determined by health outcomes, meaning over time a fundamental shift towards population health and primary care. Seven CEOs (58%) suggested transitional funding was needed to achieve this. For instance, one said:

The system must determine what impacts on health outcomes – this means a fundamental shift in the system towards population health and primary care with transitional funding (over a generation).

Within this context, CEOs considered reinvestment of savings and efficiencies should be equity-based and transparent and either directed within a program to ensure more equity or directed to other programs that will achieve improved outcomes for the most disadvantaged. There was also a strong feeling that to achieve stated outcomes, funding must be committed over longer time frames (ten years) where the focus of investment is improved equity.
**Discussion**

What does this tell us about the thinking of CEOs as this project progressed? During the development of the Equity Statement, CEOs were exposed to strategic discussion and consideration of equity and health inequalities for over twelve months. Initially, CEOs identified three questions:

1. Are health outcomes at a local or micro-level the same as equity at a population level?
2. What is the acceptable range of health status difference?
3. What are the dangers in approaching equity if the analysis is based on perception and discrimination instead of evidence?

These questions reflect and anticipate concerns and solutions put forward in a number of jurisdictions where policies to tackle health inequalities have been developed or debate has arisen over its meaning. In particular while health inequalities persist in most countries, Australia has been unable to match those developed countries with significant Indigenous populations in improving health outcomes for them in line with the rest of the community. [13] While not explicitly stated by all CEOs, the necessity of universal basic health services with equitable access to specialist services was well understood. As well, the notion of the ‘inverse care law’ was implicit in the understanding of many.

By Stage 5 of the project, all CEOs had an understanding of the key concepts of equity and recognised the extent of health inequalities as a focus for the health system. Three key strategies emerged from the consultations with AHS CEOs to inform the development of the NSW Equity Statement and Strategies documents. They were:

1. Health’s role as an equity advocate in the whole-of-government and broader system must be acknowledged, promoted and pursued if equitable health outcomes are to be achieved;
2. Linkages between health and other service providers that affect health outcomes must be encouraged and pursued; and
3. Information is the key to improving an appreciation and understanding of equity issues.

By the end of the project, CEOs had participated in interviews, workshops, the Reference Group and technical working groups, and reviewed the draft Equity Statement and Strategies to which they had contributed. Many felt that only by making the health system accountable for health outcomes, would there be pressure for system-wide changes in approaches to resource allocation. They recognised that those factors that substantially impact on health outcomes were often outside the control of the health system, which meant finding a balance in dealing with Health Care’s role in ‘rescue services’ and Public Health’s role in advocacy to which they could be held accountable. All stated that ensuring access to services based on need as a key area where they could potentially have an impact. They specifically saw four key challenges:

1. Building a focus on equity into mainstream services and the conflict with efficiency;
2. Arguing for different treatment for certain populations based on need in ways that did not marginalise them or bring accusations of special treatment;
3. Dealing with acute health/crisis management issues but allowing time and resources to invest in prevention/early intervention; and
4. Developing a rational health financing system in the Australian context.

What does this mean for health policy makers and administrators? There are two sets of questions that arise: those to do with how health systems are organised; and those that ask about its role. These are questions broader than equity and go to how more general policy making can be informed by specific case studies. With regard to the first, Mintzberg [14] suggests that managing sub-systems in health services requires recognition of the differences between services and how they are managed, and between the needs of each sub-system and how they are managed. The demand for seamlessness is more likely than not to hinder good management outcomes and associated good patient outcomes.

With regard to the second set of questions, the relationship between health and equity has revolved around the relationship between poverty and health outcomes. NSW has attempted under successive governments to address issues of socio-economic status from a population perspective through its funding mechanisms for AHS. Other jurisdictions (though not all) have followed this lead. Marmot [15] says that there are very good reasons for considering the links between health and income (which is one of the key measurements of poverty), health disparities, disadvantage and inequity. They include knowing how to address politically acceptable yet simplistic policies that purport to address health outcomes. Instead we need to understand the chain of causation from economic situation to health outcomes, the extent to which material wealth is equated with poverty.
vis-à-vis other factors including social connectedness, and the degree to which social participation and control effect health outcomes and potentially ameliorate poverty and health disparities.

Conclusion
The questions identified by CEOs are key questions. They are relevant to many developed health systems – health policy makers and researchers have addressed many of them and many countries have adopted policies and programs to tackle health inequalities, health outcomes and equity. The United Kingdom has a series of well known reports and studies that have resulted in significant increases in health funding. [16,17,18] More recently, Canada commissioned a major report [19] that examined many of the issues raised by NSW AHS CEOs, making a strong case for re-investment and increasing investment in a publicly funded and controlled health system. The key challenge for governments in Australia is responding to what many senior health policy makers and administrators identify as important, to give them the flexibility to act at the local and regional level, and to support a broad range of strategies aimed at equity-focussed health outcomes. The understanding and awareness of NSW CEOs about these issues reflects the emergence of equity as an important issue. However, the constraints and challenges that they identified also reflect the responses of health systems, in particular, in tackling health inequalities.

The NSW Health and Equity Statement was released by NSW Health in May 2004 and is available from the NSW Health website. [20] Equity remains a key strategic focus for NSW Health. [21]

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Competing Interests
The author declares that he has no competing interests.

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2. Unpublished interviews with Chief Executive Officers of NSW Area Health Services, 2000-01
12. The position that equity is as valid an economic objective as efficiency was not widely understood. See Richardson J. How should we decide which ethical preferences to include in economic analyses of the health sector. Paper presented to the Health Services Research Association of Australia and New Zealand Conference. 2001 Dec 2-4; Wellington.
13. In fact there are conflicting data in Indigenous health. While some health status indicators such as life expectancy have worsened in recent years others such as infant mortality rates have improved. However the high crime rates in Indigenous communities, extreme levels of alcohol and drug dependency and community violence continue to challenge Australia.