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Capacity Building:
JUST RHETORIC, OR A WAY FORWARD IN ADDRESSING HEALTH INEQUALITY?
Shelley Bowen, Elizabeth Harris, Jim Hyde

ISSUE ADDRESSED
It is time to move beyond defining the problem of health inequality to taking action. The response required is complex and calls for system-wide action. It is in this context that a discussion of increasing the capacity of the health system to respond to health inequality is both timely and essential.

METHODS
This paper looks at a capacity building framework that has been developed by the New South Wales Health Department and provides an example of a number of projects that have applied capacity building strategies.

CONCLUSION
Addressing health inequality presents a significant challenge to health promotion practitioners. Emerging capacity building theory provides direction for strategies to build the capacity of a health system to address equity. It proposes a set of practical actions using the five focus areas of organisational development, workforce development, resource allocation, partnerships and leadership.

SO WHAT?
A capacity building approach by itself will not provide the mandate and framework for the action that needs to be taken to address health inequality, but it helps to ensure that once potential solutions are identified the health system has the capacity to respond.

KEY WORDS
capacity building, inequality

Introduction
Health inequality and widening health inequalities have been extensively documented in Western industrialised societies around the world. Health inequalities in mortality, morbidity and burden of disease have also been well documented in Australia, with data presented by Sir Donald Acheson at the recent 12th Australian Health Promotion Conference illustrating the growing gaps in mortality rates in Australia based on area of residence. His presentation challenged health promotion practitioners to question whether they have acted on evidence that many health promotion interventions are taken up most rapidly by the most advantaged groups in the community and, conversely, not reached by those groups in the community most disadvantaged. Health promotion practitioners were also asked whether they have taken seriously the challenge of addressing health inequity by acknowledging clear social determinants in their work.

Internationally, health inequality is firmly on the agenda with major policy initiatives in the United Kingdom, New Zealand and Europe. In Australia, health inequality is emerging as a significant health issue at Commonwealth and state levels. The Commonwealth has funded the Health Inequality Research Collaboration to build Australian research capacity in the area of health inequality. Various state governments are developing policies or direction statements to address health inequality and there is a groundswell of action to address the needs of disadvantaged groups across Australia. However, moving from defining the nature and extent of health inequity and pilot projects to action which is system-wide is difficult. A number of key components need to be in place for this to be achieved:

- a mandate to act
- a framework for action
- capacity to act

This paper deals with the third of these components. It outlines a capacity building framework of strategies that has been developed by the New South Wales Health Department (NSW Health) and applies it to a health system addressing health inequality.

Definition
According to Whitehead, "Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no-one should be disadvantaged from achieving this potential if it can be avoided." Whitehead continues that based on this definition, the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same health, but rather to reduce or eliminate those that result from factors that are considered to be both avoidable and unfair. Action to address health inequality is concerned with creating equal opportunities for health. It requires more than the provision of health services and recognises that many of the opportunities for health lie outside the health system.

Emerging theory in health promotion sees capacity building as an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors. Capacity building occurs within programs, communities and the broader health system. Mapping of the domains of capacity building
demonstrates that the intent of this effort is to build health infrastructure and service development, program maintenance and sustainability, and the problem solving capability of organisations and communities. This leads to greater capacity of people, organisations and communities to promote health.12

The challenge

The evidence of health differentials in Australia based on education, employment, occupational status and place of residence is well documented.1 A recent Australian report on the burden of disease confirmed that there is a persistent social gradient in health that is reflected in both years of life lost and years with disability.4 There is evidence that the differences in health can not be fully explained by individual behaviour and traditional health risk factors such as smoking or lack of exercise.13 Connections to the social and economic environment in which people live and the control that people have over their life and social connectedness are also important predictors of health and wellbeing.5,13-15

Although much of the focus of research in the past 50 years has been on describing patterns and causes of health inequality, there is also evidence of actions that can be taken to address it.16-18 These include the provision of comprehensive primary health care services, supporting families during critical life stages, working collectively to address common problems, provision of physical and social infrastructure, and implementation of policies to ensure access to basic resources. Some of the actions that have been demonstrated to be effective need to be undertaken by the health sector alone (provision of health services), some involve health working with other sectors (supporting families in disadvantaged communities) and many involve other sectors working independently from health (income security, education and employment). There has been no systematic review of health promotion activity to address health inequality in Australia and, as King and Whitecross have pointed out, health promotion has suffered from both theoretical and political impediments to addressing health inequalities:

On the one hand, we have not fully understood the complexity of the problems; nor have we consistently applied all the theory that has been available to us. On the other hand, there has been a lack of political commitment and resources, making the attempt feeble and underpowered, so that we have not been in a position to truly test the extent to which we could make a difference (p.47).19

Addressing health inequalities presents a significant challenge to health promotion practitioners. Firstly, it challenges practitioners to reassess the source of their mandate to address health inequality and their current frameworks for action. Health promotion practitioners have extensive experience in working with individuals, communities and organisations to address health inequality. This action is often fragmented and poorly documented and evaluated. Rather than imagine that we need to invent a new approach, we need to take stock of what we are already doing and what we know to be effective.

Secondly, it challenges us to move from tokenistic or 'one-off' efforts to more comprehensive and integrated approaches to addressing health inequality. Gepkens and Gunning-Schepers undertook a review of the effectiveness of health education and health promotion programs in Europe to address health inequalities and found that many interventions that had been effective were never implemented after the evaluation or pilot period.14 This may well be the Australian experience.

Finally, addressing health inequalities challenges us to recognise that many of the causes of health inequality are firmly embedded in our social structures. It should be expected that change will be difficult and incremental. The wider values and power structures of society will influence major actions that need to be taken to address health inequality: actions such as income redistribution and provision of affordable housing and employment opportunities.

Our challenge is to decide what are feasible and achievable aspirations for the health care system in the current context. This includes convincing health services that there are effective ways for them to be involved, as well as further exploration and dissemination of better practice methods.5,6,11

The potential role of a capacity building framework

Capacity building approaches recognise the largely invisible work that is essential in building infrastructure, sustaining programs and creating problem solving capability.12 Capacity building strategies, when routinely incorporated as an element of effective practice, add another dimension to policy and program efforts to improve health.

Capacity building is not a stand-alone solution to building equity, and in fact offers guidance only on what a system needs to do to equip itself for action. Capacity building offers strategies for strengthening the capacity of a health system to respond to this challenge both within programs and at a policy level. This means:

- developing the ability to assess capacity to act,
- ensuring a skilled and knowledgeable workforce, and
- ensuring that there are organisational structures, resources and procedures in place to act.

The New South Wales Health Department has developed a framework for building capacity to improve health.11 It has identified key areas of strategy development needed to support health system efforts in improving population health. These areas are organisational development, workforce development, resource
allocation, leadership and partnerships (see Figure 1).

The framework identifies the need to assess existing capacity and build on it in an integrated way, recognising that it will not be enough to develop a health and equity policy unless there are resources available to fund initiatives or support for this type of action within the organisation. Additionally, high levels of interest by staff in addressing equity issues will have little impact unless this interest can be sustained and integrated within organisational structures and policy directions. Capacity building requires integrated action in several areas and at several levels. Case studies included at the end of each section of this paper have been chosen to specifically illustrate one or more of the key areas where action is being taken rather than to present a comprehensive analysis of the capacity building approach.

Key components of the framework

Organisational development
Organisational development relates to the range of structures, policies and management strategies that may need to be in place to achieve change. Within a government health system this will involve:

- development of policy or direction statements on equity that are supported by strategic plans to achieve agreed objectives;
- identification of senior managers responsible for addressing health inequality;
- incorporation of health equity into performance agreements and job descriptions at all levels of the organisation;
- recognition of equity as an important area of achievement in award schemes;
- development of equity indicators to monitor progress and achievements;
- development of tools such as Health Equity Audits or Health Equity Impact Assessments; and
- promotion of a culture that supports social justice objectives.

Case study 1 illustrates how this is being applied to build Aboriginal health into mainstream service plans in South Western Sydney.

Case study 1
Application of organisational development strategies
Building Aboriginal health into mainstream service plans in South Western Sydney, NSW
The evaluation of the South Western Sydney First Aboriginal Health Strategy found that there had been significant areas of achievement in either fully or partly achieving the original goals. However, the area where there had been least progress was in improving access to appropriate mainstream services by Aboriginal people.

In developing the Second Aboriginal Health Strategy, mainstream services are being required to incorporate achieving improvements in Aboriginal health in their Area Strategic Plans. Mainstream services are now responsible for developing relevant goals and strategies in collaboration with local Aboriginal health services and workers and for monitoring progress.

Workforce development
Workforce development is primarily concerned with developing the skills and knowledge of the workforce through incidental learning, informal and formal learning opportunities. The workforce includes both paid and unpaid workers (such as volunteers), consumers and community members. The range of activities could include:

- provision of opportunities for staff to learn and reflect as part of their day-to-day work;
- secondments to units with expertise in equity issues;
- scholarships and mentoring programs in equity related areas;
- specific funding to address equity issues within current work practice or participation in the implementation of equity related projects;
- development of competency based standards in work areas related to equity such as community development and needs assessment;
- sponsorship of training courses, workshops and conferences on equity related issues;
- establishment of peer support systems and opportunities for supervision; and
- review of the contribution of current work to addressing health inequality as part of routine performance appraisal processes.
Case study 2: Application of workforce development strategies

Building the skills of the health workforce to work in disadvantaged communities

The increased interest within health and other sectors in working with local communities to improve access to services and address the wider determinants of health has highlighted the need to develop a skilled workforce in these areas.

Three Sydney universities, in collaboration with NSW Health, have applied for funds to develop the skills of the public health workforce to work in disadvantaged communities. This will involve a detailed assessment of workforce needs, development of a range of training opportunities and provision of support and mentoring to those working in the field.

Resource allocation

The availability of resources is often crucial in determining if a program or set of actions can be undertaken and maintained. These resources include money, time, information, a skilled workforce and evaluated approaches to dealing with an issue, as well as practical resources such as cars and computers. The resource base for addressing health inequality would include:

- an equity based formula for the allocation of health resources across areas;
- recurrent funding of services, programs and activities that address health inequality rather than reliance on pilot programs or seeding grants;
- data on the use and reach of services by different population groups;
- provision of and access to specialist advice in areas such as needs assessment and community development;
- reviews of effective interventions and guidelines for best practice; and
- use of cars, computers and secretarial support.

Case study 3: Application of resource allocation and organisational development strategies

A census of users of community health services in the Wentworth Area Health Service

Wentworth Area Health Service has recently completed a census of all new registrations at community health services in their area. The purpose of the census was to develop a more comprehensive understanding of service use. This included collecting data on education level, employment status, social support, family composition and place of residence and relating it to the demographic profile of the area.

This information will be used to plan services and identify groups of people who may have poor access to existing services.

Leadership

Within a capacity building approach, a range of leadership styles and processes would be fostered. This relates to the development of leaders who conceptualise and integrate work across the organisation in addressing health inequality, are committed to building programs to address inequality, are responsive to consumer and community needs and who can act as teachers in challenging the system to reflect on ways in which equity can be addressed.

Leaders would:

- promote an environment that fostered risk-taking in developing new approaches to addressing health inequality;
- value the importance of engaging consumers and communities in solving problems and directing services;
- demonstrate and build skill in others in acting as advocates;
- work effectively with others in health and other sectors to provide a consistent and integrated approach by government to equity related issues; and
- develop a vision of what they hoped to achieve that could be shared with their staff and others across the organisation.

Case study 4: Application of leadership strategies

Access to health services for asylum seekers

The management group of the NSW Refugee Health Service are concerned at the problems being experienced by asylum seekers who do not have access to Medicare cards. While arrangements can generally be made for these people to see GPs or specialists free of charge, it is very difficult to organise tests and admission to hospital.

Members of the group are taking this issue up directly with the relevant government bodies at state and Commonwealth level, and indirectly through professional organisations and community groups.

Partnerships

Addressing issues of health inequality cannot be undertaken in isolation. It involves:

- developing partnerships with groups who have a strong interest in equity at a local, state and national level;
- building relationships with local communities that are based on trust and a history of health services delivering on commitments to the community;
- establishing mechanisms for joint project management that recognise the difficulties and delays in organising cross-sectoral projects;
- assessing whether the partnership activities are having an impact on the most vulnerable populations; and
- undertaking activities that are likely to be sustained in order to keep trust with the organisations and communities involved.

Case study 5 illustrates how this, and the other strategies already discussed, are being applied in the Families First program.
It builds on and informs our understanding of what strategies can be effectively taken and strengthens our mandate for action through increased organisational support. A capacity building approach is not a ‘quick fix’ to addressing health inequality. There needs to be a strong commitment to action that is based on sound understanding of causes of health inequality and evidence of effective intervention. Once a decision has been made to act on this issue, a capacity building approach provides a practical framework for ensuring there is capacity to act and to sustain effort.

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Authors
Shelley Bowen
Health Promotion Strategies and Settings Unit
NSW Health Department
Elizabeth Harris
Director
Centre for Health Equity, Training Research and Evaluation
South Western Sydney Area Health Service
Jim Hyde
University of Western Sydney and NSW Health Department

Correspondence
Shelley Bowen
Health Promotion Strategies and Settings Unit
Public Health Division
NSW Health Department
LMB 961
North Sydney NSW 2059
Phone: 61 2 9391 9955
Fax: 61 2 9391 9579
Email: sbowen@doh.health.nsw.gov.au
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