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Sustainable communities and health inequalities

Pierre Horwitz, Edith Cowan University, **Neil Drew**, University of Western Australia, **Neil Thomson**, **Meredith Green**, Edith Cowan University, on behalf of the Sustainable Communities Network

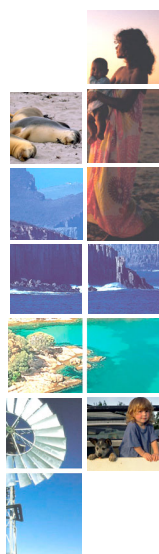
INTRODUCTION

The goal of the Sustainable Communities Network is to seek effective interventions that address health inequalities in rural, remote and Indigenous communities through sustainable development and supporting sustainable communities. The Network is part of the Health Inequalities Research Collaboration, now known as the Health Inequalities Ministerial Advisory Committee, a Commonwealth Department of Health and Ageing initiative. Its goal is to enhance Australia's knowledge of the causes of and effective responses to health inequalities, and to promote vigorously the application of this evidence to reduce health inequalities in Australia. This Committee was established in response to the increasing concern for health inequalities and research about the social determinants of health. Much of this energy has come from the UK, with the Black Report (Black, Morris, Smith & Townsend, 1980), followed by the Independent Inquiry into Inequalities in Health Report (Acheson 1998). The World Health Organisation also commissioned a report collating the social determinants of health ((Marmot & Wilkinson, 1999; Wilkinson & Marmot, 1998). In Australia Turrell, Oldenburg, McGuffog and Dent (1999) have reviewed Australian research on socioeconomic determinants of health.

The research from these and other reviews and studies shows that people who experience social and economic disadvantages tend to be sicker and die younger than others do. These health inequalities are compounded by complex biological, behavioural, cultural and geographic factors. The Sustainable Communities Network captures the breadth of these factors by adopting the concept of sustainability as a way of addressing health inequalities.

Sustainability can be broadly defined as "meeting the needs of current and future generations through simultaneous and integrated environmental, social and economic improvement" (adapted from The Western Australian State Sustainability Strategy: Consultation Draft, Government of Western Australia, 2002). To focus an understanding of the relationship between health and sustainability, the Network is divided into four working areas. The first three, listed below are the substantive working areas, while the last one is the methodological working area.

- impact of policy on service delivery, resource allocation and community development
- community capacity in relation to health, environmental and socio-economic change
- environmental justice, environmental risk and the experiences of vulnerable communities



- trans-disciplinary, cross-sectoral and participatory approaches.

In summary the key characteristics of the Network are:

- to identify evidence-based interventions for healthy sustainable communities
- the adoption of broad definitions of health and sustainability
- its position to act as a conduit between research, policy and practice, rather than conduct research
- that while being based at Edith Cowan University, the network is national
- to synthesise and collate information from different disciplines, different sectors and the community.

The policy interventions identified through discussions at workshops and bulletin boards will be presented to the Commonwealth Department of Health and Ageing at the beginning of 2004.

The objectives for this symposium were to:

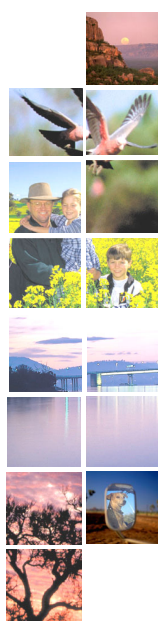
- identify three tangible policy interventions to improve the health of our rural communities
- present one aspect, a question and/or suggestion from each of three substantive working areas
- contribute to the discussion and recommendations of this conference.

This paper outlines the three different discussions from each of the three working areas.

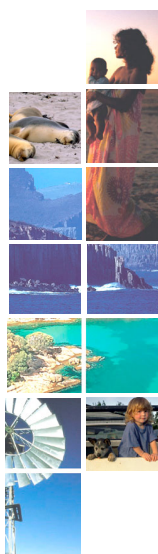
QUESTION ONE: COMMUNITY CAPACITY AND HEALTH INEQUALITIES IN RURAL COMMUNITIES: WHAT IS IT? DOES IT HELP OR HINDER POLICY?

There are a number of definitions of community capacity, as well as a number of overlapping concepts, such as social capital and social cohesion. One definition is "...the characteristics of communities that affect their ability to identify, mobilise, and address social and public health outcomes." (McLeroy, 1998 cited in Goodman et al., 1998, p.259). Another way of defining community capacity is "...the cultivation and use of transferable knowledge, skills, systems, and resources that affect community- and individual-level changes consistent with public health related goals and objectives." (Rogers, Howard-Pitney & Lee, 1995, cited in Goodman et al., 1998, p.259). Different dimensions of community capacity can also be identified; these are listed below.

- *Participation and leadership* – is required to build strength and organisation in the community and for the development of community capacity.



- *Skills* – refers to skills such as planning, co-ordination, advocacy, management, problem solving, and conflict resolution.
- *Resources* – this is not only about accessing resources, such as traditional capital, social capital and technology, but also the ability to use them prudently.
- *Social and inter-organisational networks* – refers to the structural characteristics, relationships and benefits of networks needed to be considered in evaluating their value. It impacts a community's ability to mobilise action and problem solving.
- *Sense of community* – is about belonging, influence, fulfilment of needs and emotional connection. It impacts on how local concerns are dealt with.
- *Understanding of community history* – influences a community's willingness for change and views of the future. Having access to historical information increases a community's capacity to effect change.
- *Community power* – is an amalgamation of sense of community, leadership, resources and a shared concern. It can be understood as the application of social capital that enables a community to create or resist change.
- *Community values* – refers to the ability of a community to clearly define a shared value orientation, but also is concerned with how consensus of values is achieved. Values underlie the other dimensions of community capacity and are part of the process and outcome of realising community capacity.
- *Critical reflection* – involves the ability to reason logically, scrutinise arguments for ambiguity, challenge assumptions, and integrate social justice values into alternative visions for the community. It is important in maintaining the change efforts of the community. (Goodman et al., 1998).



In considering the relationship between income inequalities, health and social cohesion, research found that socio-economic status is a strong predictor of health, but that it is relative income rather than absolute income that predicts health at least in developed countries like Australia (Wilkinson, 1992; Wilkinson, 1996). Closer examination of this research has suggested that social cohesion acts as a pathway through which relative income influences health (Kawachi, Kennedy, Lochner & Prothrow-Stith, 1997; Kawachi, Kennedy & Glass 1999).

However the proposal that health is related to social cohesion has been critiqued for a number of reasons. One of the main debates is around whether the relationship between health and social cohesion might be better explained by the domination of market forces in the decision making in our society, or what has been referred to as neo-liberalism (Coburn, 2000). According to the neo-liberal view the provision of welfare interferes with the “normal” functioning market, and as such should not exist. As well as this the neo-liberal approach is individualistic and supports the privatisation of the public sphere. Most developed countries are organised around these principles to some degree. The argument in relation to social cohesion's impact on health is that neo-liberalism reduces both social cohesion and health status, rather than the two being related. As such it is asserted that attending to social cohesion in an effort to improve health is a waste of time because neo-liberal principles will undermine these processes.



Drawing on these arguments we concluded that:

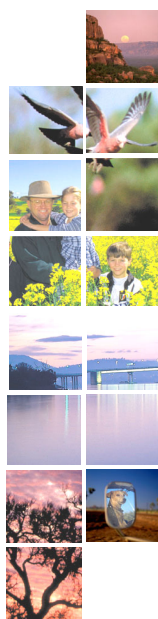
- capacity matters – but it is poorly understood.
- capacity matters – but on its own will fail to deliver on behalf of health inequalities
- capacity matters – as part of the matrix of regional development imperatives
- capacity matters – as part of a reorientation of regional governance.

So this leaves us with the proposition that while community capacity may be important in addressing health inequalities, the current processes and structures of government and policy making may not have the capacity or be appropriate for the development of community capacity (Stewart-Weeks, 2000; Bush & Baum, 2001). In addition to this it has been suggested community capacity may be more effectively developed at the local level (Stewart-Weeks, 2000). In considering the development of community capacity at a local level, some lessons gleaned from a review of regional programs by the Bureau of Transport and Regional Economics (BTRE) may be helpful, these include:

- well integrated and stable governance, the so called joined up approaches
- role of business and investment to promote economic development and employment
- evaluation and evidence-based policy
- development of human and social capital; endogenous strategies, industry clusters and innovation
- long-term locational approach
- flexibility (BTRE, 2003, pp 59–63).

Capacity matters, but may be more effective in addressing health inequalities if regional governance is reorientated to allow for the development of community capacity. One example of this is the Harvard Governance Project (Cornell, 2002). The Harvard project exemplifies innovative approaches to governance for first nations people in North America and Canada and provides some lessons for governance in rural, regional and remote areas generally. In essence, the results of the Harvard Project indicated that it was not economic opportunity that made the difference between success and failure to deliver outcomes to the wider community. Many first nations groups had sources of considerable income, for example a casino on their lands, while others had very little. This was not the critical variable. Four factors were found to be related to positive outcomes.

- Jurisdiction: The researchers did not find a single case of sustained success in first nations communities where the Indigenous people did not have control over the decisions.
- Effective governing institutions: Regardless of the actual structure governing institutions must have stability, efficiency and workable conflict management processes.



- Cultural match: The governing institutions must have a good cultural math. In other words they must be appropriate and acceptable to those governing and being governed. They may look very different in different settings. There is no “one size fits all”.
- Strategic thinking: there must be a shared vision of the where the society or community is going. Without the power derived from jurisdiction or sovereignty there is little incentive for strategic thinking.

The outcomes of research such as the Harvard Project issue real challenges to policy and decision makers to rethink the nature of governance in rural, regional and remote communities. Regional jurisdiction and autonomy may provide opportunities for development that embrace the observations of the BTRE report and break the nexus between income disparities and health inequalities by enabling the development of community capacity.

QUESTION TWO: WHAT IS THE ROLE FOR HEALTH IMPACT ASSESSMENT IN ADDRESSING HEALTH INEQUALITIES?

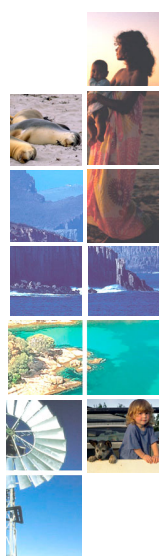
Health Impact Assessment (HIA) “...is a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population (European Centre for Health Policy, 1999, p.4). The goal of HIA is to maximise the benefits and minimise the harms to health that may be caused by policies and projects outside the health sector (Parry & Stevens, 2001). It endeavours to achieve this through creating a more inclusive and evidence-based approach to policy formulation and decision making (Mahoney & Morgan, 2001).

HIA has originated from two different sources; the first is the extension of Environmental Impact Assessment (EIA) (Douglas et al., 2001; Kemm, 2001; Mahoney & Morgan, 2001). The second is through the notion of healthy public policy that developed from the Adelaide Conference on Healthy Public Policy in 1988 and states that:

... in the pursuit of healthy public policy, government sectors concerned with agriculture, trade, education, industry, and communications need to take into account health as an essential factor when formulating policy. These sectors should be accountable for the health of their policy decisions. They should pay as much attention to health as to economic considerations. (World Health Organisation, 1988).

Recent developments in HIA have occurred in:

- the Canadian states of British Columbia and Quebec;
- the Netherlands, Sweden, Finland and Ireland through the Amsterdam Treaty which calls on the EU to examine the impact of major policies on health;
- the United Kingdom, where government reports recognised in the issue in the late 1990s and where much action at the local level has occurred; and
- New Zealand, where the focus has been on environmental health impact assessments.



In Australia the NHMRC has focused on environmental health impact assessment, although Draft Health Impact Assessment Implementation Guidelines were developed by enHealth in 2000 (enHealth Council, 2001) and further research into HIA for Australia has been commissioned by the Commonwealth Department of Health and Ageing. In addition a national PHERP funded project is currently under way to investigate Health Inequalities Impact Assessment. In Tasmania HIA is a mandatory component of the EIA process.

In deciding what approach to take in HIA the following tensions exist and need to be considered:

- broad focus (holistic view of health) vs tight focus (physical health)
- national vs regional vs local scope
- rapid vs intermediate vs comprehensive level of HIA
- quantitative vs qualitative
- expert drive vs community (inclusive) approach (see Lock, 2000; Mittlemark, 2000; Kemm, 2001; Mahoney & Morgan, 2001; Parry & Stevens, 2001).

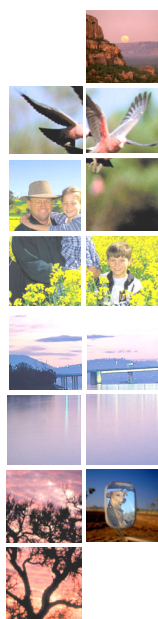
Other questions to consider when thinking about the approaches to HIA relate to the nature of evidence and its evaluation, in particular how is health to be measured and how can a range of evidence, including that from the grey literature be synthesised. A number of questions also exist around stakeholder consultation, including how can we ensure it is balanced and reliable, how it may be an intervention in its own right, and whether it may off load unpalatable political decisions on to the community. Finally there are questions about the accuracy of predictions, how predictions might be affected by population changes and other changes over time, is the data these predictions are based on substantive and reliable.

In regards to health inequalities policies improving the overall health of a population, for example smoking prevention programs and cervical cancer screening, may have no impact on inequalities in health. General HIAs may inadvertently increase inequalities. To address this particular disadvantaged groups or inequalities across the population need to be considered through Health Inequality Impact Assessment. All HIAs should focus on inequalities through:

- increased awareness of inequalities and their causes
- improvement in decision making seeking to prevent inequalities
- making decision making more transparent and accountable. (Mahoney & Morgan, 2001).

Focusing on implementation of HIAs, the following issues need to be addressed.

- Whether the approach will be based on the EIA model, or on a broader model based on Healthy Public Policy and incorporating the social determinants of health?



- Whether to restrict HIAs to rapid or mini HIAs or to have maxi or comprehensive HIAs?
- To ensure that the essential features of rigour, inclusivity, thoroughness and predictive accuracy are included in HIA.
- Whether HIA should be separate from or include Health Inequality Impact Assessments?
- How is the community included in the assessment process?
- How do national/regional/local HIAs take into account international/trans-national policies?

One issue for the development and implementation of HIAs is whether such a process emphasises the health sector over other sectors, that may also experience impacts due to the policies and programs of other sectors, including health.

In conclusion,

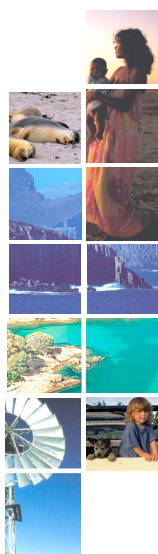
HIA may indeed be an idea whose time has come, if it is supported by political will and if we develop coherent strategies for implementing an efficient and sustainable HIA process...[which is] institutionalised as part of existing decision-making processes. This challenge has to be met if we want the dream of effective public policies to come true. (Banken, 2001, p.6)

In Australia there is a need to implement HIA in such a way that the impact on inequalities (for specific groups across the population) is an integral part.

QUESTION THREE: ECOLOGICAL INTEGRITY AND HEALTH INEQUALITIES IN RURAL COMMUNITIES: WHERE'S THE EVIDENCE? AND WHAT ARE THE POLICY INTERVENTIONS?

Intimate relationships between the well-being of people and their surroundings are ingrained in some cultures. We often hear of Indigenous concepts of land as mother, and caring for country, where the land is water, earth, fire, living creatures, interwoven with culture. There are also concepts of degradation and loss of country (usually latterly associated with dispossession) and its concomitant consequences for individual and cultural well-being.

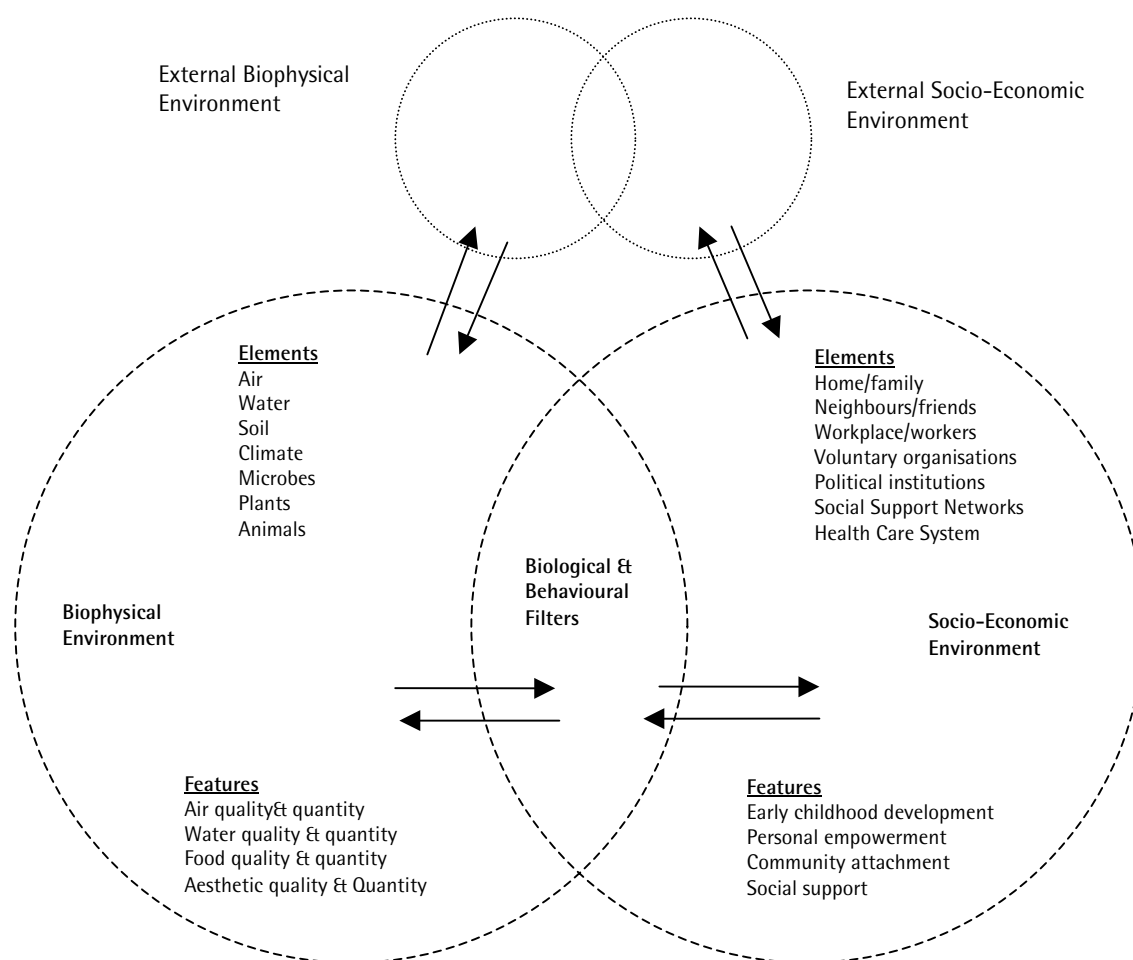
Simple notions of environmental health, practiced regularly in Australia, portray the land and the well-being of people as disconnected from one another and that our surroundings are instrumental to our well-being. Food, shelter, fabrics and so on are considered important in terms of our material gain and well-being, and the relationship between health and the environment is considered as one way, causal, and linear: where the environment impacts on our health. There are, of course, many examples of the benefits brought by this simple conceptualisation, such as recognising the health consequences of environmental pollution, the health improvements due to adequate sanitation, and addressing the effects on mental health of environmental disasters and catastrophes. Although one might argue that disparities still exist



between urban and rural beneficiaries in these terms, it denies (or understates) a reciprocal impact that we have on our environment.

Another approach to considering the relationship between health and the environment is to consider it as an intimate two-way relationship, where healthy ecosystems are ones that have particular ecological attributes (Karr, 1997; VanLeeuwen, Waltner-Toews, Abernathy and Smit (1999). This approach reaffirms the importance of the biophysical conditions of our surroundings (that have their own health too). It recognises that the condition of our surroundings is a product of our behaviour, attitudes and culture (illustrated in the diagram below), involving a suite of dynamic, reciprocal and complex relationships that become multi-layered over time, and in each place. We choose to articulate health using this model where biophysical and socio-economic determinants of health pass through behavioural and biological filters.

Figure 1 Butterfly model of health



Source: adapted from VanLeeuwen et al. 1999.

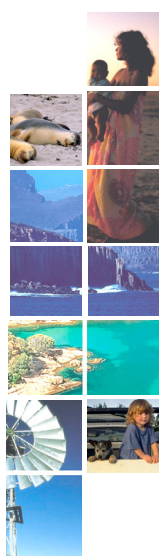
In its totality, the model could also embrace the relationships between sustainability and health. The idea of relating the notions of sustainability and environment to health is not a new one to either the environment or health sector. The so-called Brundtland Report (*Our Common Future*) published in 1987 embodied this relationship. In 1988 at the Adelaide Conference on Healthy Public Policy the following two statements were made:

Public health and ecological movements to join together in pursuit of socioeconomic development and the conservation of our planet's limited resources.

Policies promoting health can be achieved only in an environment that conserves resources through global regional and local ecological strategies.

Again, last year at the Johannesburg World Summit on Sustainable Development 2002, the understanding of sustainable development was broadened and strengthened, particularly the important linkages between poverty, the environment and the use of natural resources.

However, where is the evidence that natural resource management decisions, or the activities of the environmental sector in general (water industry, forestry, agriculture, fisheries etc), will lead to reduced health inequalities? The evidence comes in different ways: theoretical, empirical, qualitative, narrative. For instance:



- Climate change – our behaviour (ie. burning fossil fuels, land clearing) is changing the temperature, distribution of rainfall and humidity. These climate changes have a range of consequences for individual health and community identity (see McMichael 2001).
- Emerging diseases – our behaviour in the health (biomedical) sector producing the conditions under which old diseases can re-emerge or new diseases can evolve.
- The sorts of health/environment relationships that develop over a long time, where environmental and social determinants behave in a synergistic, cumulative, non-linear way and where it is often impossible to extract evidence, except in the form of narratives from local and individual voices.
- Environmental change and mental health (mediated through a sense of place) ie. drought, loss of biodiversity, soil erosion and salinity, where issues of intractability and complexity of a changing place translate to helplessness and hopelessness (Horwitz et al. 2001).

At a higher level policy interventions need to consider:

- sharing strategic advice (across sectors)
- adopting a sharing language that allows for mutual understanding
- moving towards a cross-sectoral alignment of regional service delivery
- adaptive iterative evaluative participative approaches to decision making that involve the natural resource management sector in concert with the health sector.

One good example of the need to align strategic advice and language is in the word “sustainability” itself. The Healthy Horizons: Outlook 2003–2007 states that “People in rural regional and remote Australia will be as healthy as other Australians and have the skills and capacity to maintain healthy communities”. Sustainability is mentioned as one of the eight principles for this to occur along with primary health care, public health, capacity of communities, community participation, access, partnerships and collaboration, and safety and quality. But “sustainability” seems to be defined in the



narrow sense as ensuring the perpetuation of programs and policies, rather than the broader sense used in this paper.

Taking a broader understanding of “sustainability” as discussed by the Network highlights the importance of the health sector being included in decision making in the natural resource management sector. The Natural Heritage Trust MkII is currently being rolled out across Australia at the regional level through the establishment of The Natural Resource Management Councils. This is one instance where the question “How do we know that the actions emanating from this development (natural resource management intervention) will help residual health issues (like those from the drought, or the fires in south-eastern Australia)?” can be asked. Other, more specific, questions might include “How do we know that these actions will help prevent the health effects of the next drought?” In conclusion policy interventions from the NRM sector need to be explicitly influenced by the health sector and evaluated for their health effects at the regional level.

CONCLUSION

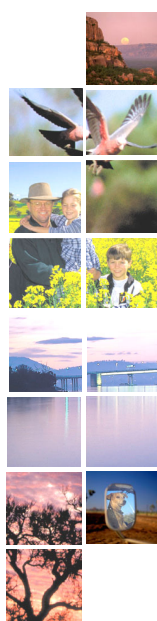
Each of these discussions poses a possible policy intervention that may be presented to the Commonwealth Department of Health and Ageing as part of the Network’s final report and recommendations. Summaries of these three possible interventions are listed below.

- For community capacity building to impact on health inequalities, assessment must be driven within the matrix of regional development to ensure things like income inequality are addressed.
- There is a need to implement HIA in Australia in such a way that the impact on inequalities (for specific groups and the overall population) is an integral part.
- Policy interventions from the NRM sector need to be explicitly influenced by the health sector and evaluated for their health effects.

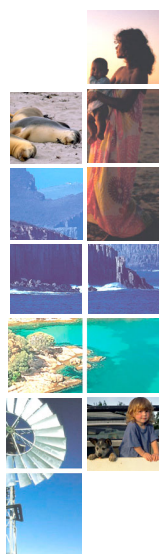
These three statements are not conclusive and each require further refinement and debate. Please be involved in the further development of these and other policy interventions by visiting the SCN website at <http://scn.ecu.edu.au> or contacting SCN Co-ordinator at meredith.green@ecu.edu.au.

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