An Equity-focused health impact assessment of the Healthpact Community Funding Program

FINAL REPORT

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on behalf of the
*Health**pact** EFHIA Steering Group*

ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

An equity-focused health impact assessment (EFHIA) of the ACT Health Promotion Board's (Health**pact**) Community Funding Program (CFP) was undertaken to determine the potential health inequalities impacts of the program and how the equity-focus of the CFP might be strengthened. The intent of the program is to add value to existing health promotion activities in the ACT and to encourage new and/or innovative health promotion approaches.

Equity in health is an important public health issue because inequities in health limit life opportunities and health gain. However practitioners encounter significant difficulties in translating commitments to achieving equity in health into actual, practical, workable interventions. Equity-focused HIA shows promise as a decision-support tool by providing a structured process for generating information about the potential health and equity impacts of a proposal. This information can be used by decision-makers to improve a proposal by mitigating potential negatives and strengthening potential positives.

The first five steps of an equity-focused HIA have been completed: screening; scoping; identification of impacts; assessment of impacts; and development of recommendations. Information for the identification of impacts was collected through: a review of the literature on health promotion and health inequalities; a review and analysis of key ACT policy and program documents; interviews with key informants in the ACT; a half-day workshop with community and government organisations and consumers; and a content analysis of all applications received as part of the 2003/2004 funding round.

Overall the CFP was viewed as having the potential to positively impact on health inequalities in the ACT. There are a range of ways however in which the equity-focus of the program can be strengthened including development of a specific commitment to equity, greater clarity about the program objectives, focus areas, project types and

priority population groups. Undertaking the EFHIA also highlighted the challenges with the assessment and recommendation steps of HIA/EFHIA particularly where there are different views about potential health impacts, the nature and extent of these impacts and how to address these potential impacts.

ABBREVIATIONS

ACHEIA	Australian Collaboration for Health Equity Impact Assessment
ACT	Australian Capital Territory
ACT Health	ACT Government health portfolio
CALD	Culturally and linguistically diverse
CHETRE	Centre for Health Equity Training Research and Evaluation
CFP	Community Funding Program
EFHIA	Equity-focused Health Impact Assessment
Healthpact	The ACT Health Promotion Board
HIA	Health Impact Assessment
NIPH	Newcastle Institute of Public Health
PHERP	Public Health Education and Research Program
UNSW	University of New South Wales

1. INTRODUCTION

1.1 Background

The Australian Government, through its Public Health Education and Research Program (PHERP) funded the development of a framework for equity-focused health impact assessment (EFHIA). This project is being undertaken by the Newcastle Institute of Public Health (NIPH), Newcastle University in partnership with Deakin University and the Centre for Health Equity Training Research and Evaluation (CHETRE), University of NSW. Five case studies (in Australia and New Zealand) have been undertaken to test the EFHIA framework. One of the case studies was a retrospective EFHIA of the Healthpact Community Funding Program (CFP). The other case studies included:

1. Assessing the equity impact of the New Zealand Ministry of Health "Healthy Eating: Healthy Action" policy, which was written with specific reference to Maori health.
2. Application of EFHIA to components of the Royal Australasian College of Physicians' Support Scheme for Rural Specialists.
3. Application of EFHIA to the National Health and Medical Research Council's guideline "Healthy Eating for Older Australians".
4. Assessing the health impacts of the John Hunter Hospital's outpatient Cardiac Rehabilitation Program.

1.2 Why an EFHIA of the Community Funding Program?

The Health Improvement Branch, ACT Department of Health were involved in discussions about possible case study sites at the beginning of the PHERP project. They approached Health**pact**, who nominated the Health**pact** Community Funding Program because the ACT Health Promotion Board have a strong commitment to evidence based practice and wished to use the EFHIA to assess:

- the potential impact of the CFP on health inequalities in the ACT and
- identify what aspects of the CFP processes could be changed to strengthen the equity focus of the program

More broadly, the ACT Health Promotion Board (Health**pact**) EFHIA case study results regarding the potential impacts of similar funding programs will be shared with other health promotion funding agencies in Australia and internationally, including: VicHealth; Healthway; Thai Health; Austrian Health Promotion Foundation; Switzerland Health

Promotion Foundation; Hungary 21 Foundation; Malaysia Health; and Korea Health. A copy of the report from the EFHIA will also be sent to the World Health Organisation. This report is written with all of these potential audiences in mind.

1.3 Status of Healthpact EFHIA

There are six steps to be undertaken as part of an equity-focused health impact assessment:

1. Screening – is an equity-focused HIA required?
2. Scoping – setting the parameters of the EFHIA – eg. how information will be collected
3. Identification of impacts – developing a profile of the relevant population & sub-populations and collecting the information on health impact – usually through a range of different sources.
4. Assessment of impacts – assessing the information collected during the identification step, assessing whether there are any differential impacts and assessing whether these potential differential health impacts are inequitable.
5. Developing recommendations based on the findings
6. Evaluation and monitoring.

Steps one to five of the Healthpact EFHIA of the Community Funding Program have been completed.

*1.4 Management of Health**pact** EFHIA*

The Health**pact** EFHIA was undertaken by Sarah Simpson, Program Manager HIA, CHETRE, supervised by Liz Harris, Director, CHETRE and in liaison with Elizabeth Gaukroger, Program Manager Research & Evaluation, Health**pact**.

1.5 Steering Group

The Health**pact** EFHIA was overseen by a Steering Group comprising:

1. Ms Sam Moskwa, Director, Health**pact**
2. Ms Elizabeth Gaukroger, Program Manager, Health**pact**
3. Emeritus Professor Val Brown, Member, ACT Health Promotion Board
4. Ms Elizabeth Harris, Director, CHETRE (Chair)
5. Ms Sarah Simpson, Program Manager HIA, CHETRE

1.6 About this report

This document presents a final report on the main outcomes of the EFHIA to date, the main findings of the EFHIA and draft recommendations for consideration by the ACT Health Promotion Board. More detailed reports on the screening and scoping steps are available if required.

The majority of this report has been prepared by Sarah Simpson in her capacity as the person undertaking the EFHIA and on behalf of the Steering Committee, however two sections (Sections 2 and 13) were prepared by the Health**pact** secretariat. These two sections are not based on findings made as part of the EFHIA.

2. A PROFILE OF CANBERRA

2.1 Introduction

The ACT Healthpact Health Promotion Board undertook to identify methods by which health inequalities can be redressed in the ACT community by assessing the methods of funding and program types for the years 2003 – 2004. The ACT does not have the extremes in regional poverty rates found in other parts of Australia, possibly due to the small size of the population and the relative homogeneity in terms of income levels, occupation and industry types. However, the experiences of those that do experience marginalisation and disadvantage are exacerbated due to a number of factors: poverty is not highly concentrated in a number of suburbs; children are two and a half more times likely to be in poverty than adults; the high poverty rates and/or risks indicate a significant number of people experience entrenched poverty, and conversely, poor Canberrans are less likely than all poor Australians to be part of a couple with children, families and working poor.

Many of the health promotion messages in Canberra are based on prevention messages which rely on an individual's capacity to heed the prevention message – to change their lifestyle, to become educated, to participate in group activities and/or access health services as required. Of course, this capacity is unequally distributed across the whole of the population, and are of benefit to those who are most able to take up and act on the advice, without benefiting those who cannot.

In this way, paradigms that promote individual health may exacerbate the health inequalities in the community by those who are less able to actively participate in the community: the aged people, children, people who live with mental health issues, Aboriginal and Torres Strait Islander people, young people who are not in school and people who experience homelessness.

The following information (Section 2.2-2.6) provides a context in which the EFHIA study should be viewed and is taken from directly taken from *Building Our Community. The Canberra Social Plan* ((Chief Minister's Department, 2004) pages 18 – 24). While the majority of the community experience good health, those who do not experience acute marginalisation and are disadvantaged in multiple ways.

At the end of this report (see Section 13) is a postscript that provides information about the work of the Healthpact Health Promotion Board to develop systems and enhance the participation of representative of people who experience marginalisation. These activities aim to redress health inequalities in the ACT.

2.2 ACT Residents

In June 2003, an estimated 322,850 people lived in the ACT. Canberra has a relatively young population, with a median age of 33.8 years in 2003, compared with 36.1 for Australia overall. Although, there are similar proportions of people aged less than 15 in the ACT and Australia at around 20 per cent, the ACT has only 9.1 per cent of people aged over 65 years, compared with 12.9 per cent nationally.

The 2001 census showed that over one-fifth of the ACT population was born overseas. Aboriginal and Torres Strait Islander people comprised 1.1 per cent of the ACT population. The Aboriginal and Torres Strait Islander population is significantly younger than the general population, with approximately 46 per cent under 18 years of age. The median age of the Aboriginal and Torres Strait Islander population was 20 years, around 13 years younger than for the non-Indigenous population.

There were 122,884 ACT households in 2002, with an average of 2.5 people per household, slightly less than the national average.

There were 83,100 families (two or more related persons living together) in the ACT in 2003. Couple families make up 81 per cent of family types, while one-parent families accounted for 18 per cent. Of couple families, 40 per cent had children under 15, while 55 per cent of one parent families had children under 15.

Some 55 per cent or 27,800 children in the ACT used some form of formal or informal childcare.

In 1998, there were 5,200 people in households with a primary carer role, providing the majority of care to members with disabilities. A further 38,000 people had roles as non-primary carers. Females comprised 83 per cent of the primary carers, with the peak age for primary carers at 35-44 years.

2.3 Living Standards

Canberrans have the highest disposable incomes in Australia with an annual disposable income per capita of $36,831 in 2002-03, compared with $24,677 for Australia overall. Average weekly earnings for full-time employed people in the ACT were also higher at $978 in 2002, compared with the national level of $873. However, the gender disparity in earnings has continued with males earning on average 17 per cent more than females in full-time employment.

The ACT has the lowest unemployment in Australia. In 2002-03, the official unemployment rate averaged 4.4 per cent, compared with 6.5 per cent nationally. Youth unemployment was considerably higher, with a rate of 16.5 per cent, although this too was lower than the national figure (19.2%) and lower than any other time in the last decade. The ACT's lower unemployment is also associated with higher participation in the labour force. Almost three-quarters or 73 per cent of people aged 15 to 64 years were in the labour force compared with 64 per cent nationally. In 2002-03 an average of 1,300 Canberrans were long-term unemployed - that is, out of work for 12 months or more.

While the ACT population is wealthier overall than other Australians, there are still some households with relatively low incomes. Close to one-in-thirteen adults and one-in-nine children live in poverty. A study on poverty in the ACT indicated that people living in financial hardship are more likely to be young, in receipt of government cash benefits, living in public housing, in lone-parent households and unemployed. In the ACT, the average disposable weekly income of low income households was $342 in 2000-01, compared with $246 nationally.

Government pensions and allowances were the principal source of income for 15.4 per cent of ACT households, compared with 28.3 per cent for Australia. This reflects the ACT's lower unemployment and a higher proportion of people of working age than other States. ACT households are also more likely to have multiple earners, with an average of 1.4 earners per household, compared with 1.1 nationally. Around 60 per cent of ACT women with children aged less than five years were also in the labour force, compared to around 50 per cent nationally.

2.4 Health and Well-being

Health indicators for Canberrans compare favourably with other jurisdictions. Life expectancy at birth for the ACT has increased steadily. At around 83 years for women and 79 years for men, it is higher than the Australian average and is amongst the highest in the world.

There were around 53,000 people with a disability in 1998. Of these 38,100 had a core activity restriction and needed assistance with self-care, communication or mobility.

The 2001 National Health Survey found 27,500 people, or 8.8 per cent of the population in the ACT reported a long-term mental or behavioural disorder. The survey also showed that 10 per cent of Canberrans were experiencing high levels of psychological distress.

ACT adult residents are generally satisfied with their health status. In 2001, 54 per cent of Canberrans over 15 years reported they had ‘very good’ or ‘excellent’ health.

2.5 Education and learning

People in Canberra continue to have the highest levels of educational attainment in Australia. Some 65.5 per cent of the population aged 25-64 years had a post-school qualification in 2003, compared to the national average of 55.3 per cent. Thirty-six per cent of Canberrans aged 25-64 years had a bachelor’s degree or higher.

2.6 Housing

There were 114,842 occupied private dwellings in the ACT in 2001. Houses accounted for 76 per cent, townhouses 13 per cent and flats/units 10 per cent. Of the occupied private dwellings in the ACT, 33 per cent were fully owned, 33 per cent had money owing on a mortgage and 28 per cent were being rented.

The ACT has the highest proportion of households residing in public housing. In 2002, nine per cent of ACT households were in public housing compared with five per cent nationally.

The ACT has the highest proportion of Supported Accommodation Assistance Program (SAAP) clients remaining in crisis accommodation. In 2002-03, 63 per cent of ACT people

who entered crisis accommodation achieved independent housing at the end of the support period, compared with 72 per cent nationally. The proportion of clients moving to private rental housing was the lowest of any State or Territory at 19 per cent with a national average of 39 per cent.

Homelessness was estimated to affect around 1,230 Canberrans at any one time in 2001. The number who sleep rough (primary homelessness) each night was between 120 to 315 people.

3. DEFINITIONS

3.1 What we mean by 'health'

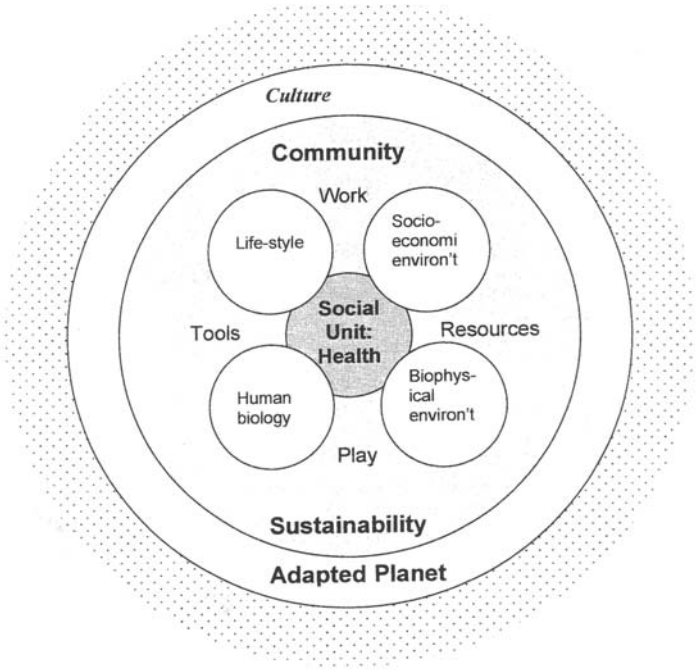
An Aboriginal definition of health reflects both the importance of context (health inequalities in Australia) and acknowledges the broader perspective that Aboriginal Australians have on "health", how it is created, protected and promoted. This is particularly important given Aboriginal Australians experience the most significant health disadvantage – or the most extensive health inequities – than non-Aboriginal Australians. (National Health and Medical Research Council, 2003) The Winnunga Nimmityjah Aboriginal Health Service do not have an ACT specific definition and use the National Aboriginal Community Controlled Health Organisation's (NACCHO) definition of health where Aboriginal health is:

> … *holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to well being. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal ill health will persist.* ((National Aboriginal Community Controlled Health Organisation, 2003) p.5)

The NACCHO definition is underpinned by nine guiding principles including; self determination; the need for culturally valid understandings to shape the provision of services; recognition and respect for the human rights of Aboriginal peoples; that racism, stigma, environmental adversity and social disadvantage are ongoing stressors and have negative impacts on Aboriginal people's mental health and well-being; recognition of the centrality of Aboriginal family and kinship; there is no single Aboriginal culture or group but numerous groupings, languages, kinships and tribes plus ways of living; and recognition that Aboriginal peoples have great strengths, endurance and a deep understanding of the relationships between human beings and their environment. (National Aboriginal Community Controlled Health Organisation, 2003)

Applicants for the 2004/2005 CFP funding round were asked to frame their projects within the Mandala of Health model (adapted from Hancock and Perkins 1986), which provides a systems model of the human ecosystem and takes a more holistic approach to health promotion. Two gaps in the 1986 model (the socioeconomic and

biophysical environmental structures and processes that influence health) (VanLeeuwen et al., 1999) have been addressed in the Health**pact** adaptation of the model in Figure 1 below:



The Steering Group agreed that the NACCHO and Health**pact** definitions/understandings of health would apply to the Health**pact** EFHIA.

3.2 The social determinants of health

Most health is created outside of the "health" system and by determinants that lie outside of the "health" sector such as education, transport, housing and employment (Wilkinson and Marmot, 2003). These are known as the social determinants of health.

3.3 What we mean by equity

Equity is about equal access to services for equal need, equal utilisation for equal need and equal quality of care for all, with a focus on health outcomes. An equity approach recognises that not everyone has the same level of health or level of resources to deal with their health problems and it may therefore be important to deal with people differently in order to work towards equal outcomes. These ideas have been summarised by Margaret Whitehead:

> *Equity in health implies that ideally everyone should have a fair opportunity to attain their full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. 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 level of health, but rather to reduce or eliminate those, which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating opportunities for health and with bringing health differentials down to the lowest levels possible.* (Whitehead, 1990)

This definition relates to access of service provision, utilization and outcomes and as noted previously many of the factors that contribute to health inequities lie outside the control of the health system. To this end the CFP focuses on funding of projects that address the social determinants of health with a view to creating environments and communities that promote health and healthy people. The principles of the Margaret Whitehead's definition are still of relevance to the Health**pact** EFHIA however because the focus is on:

1. Identifying those potential health differences resulting from factors that are considered to be both avoidable and unfair (eg. lack of education) **AND** on making a judgement about whether these potential differential health impacts will be, are, or were, inequitable – that is, avoidable and unfair.
2. Reducing the potential for these differential impacts to become health inequities by using the findings from EFHIA to amend, ameliorate and improve the proposed policy, program or project (ideally before it is implemented).

For a definition of differential health impacts please see the Glossary.

3.4 Defining disadvantage

"Disadvantage" is a pattern of limitation of life opportunities in health or in social or economic wellbeing. Socioeconomic disadvantage is known to limit life opportunities in particular due to poorer health. "Disadvantage" may be defined in many ways including in terms of socioeconomic status, of position or occupational status, and/or health outcomes or illness for example a person might be considered disadvantaged because their illness

limits their opportunities in life. It is also important that in defining disadvantage (as a way of creating clarity about the intended recipients of a funding program) that it is done so as to raise awareness of the particular needs of population groups and not to "other" a group of people.

3.5 Health impact assessment

The most commonly cited definition of health impact assessment is:

> *A **combination on procedures, methods and tools** by which a **policy, program or project** may be assessed and judged for its **potential, and often unanticipated, effects** on the **health of the population** and the **distribution of these impacts** within the population.* (European Centre for Health Policy, 1999, Mahoney and Morgan, 2001, Mahoney and Durham, 2002)

For further information see the Glossary.

3.6 The purpose of health impact assessment

Health impact assessment provides a structured process for engaging key stakeholders in negotiations and recommendations. The aim of HIA is to improve a proposal by identifying potential health impacts and developing solution focused recommendations to improve the proposal **before** implementation: thereby contributing to improved decision-making and policy development. The value of undertaking HIA as opposed to doing a research project/evaluation is that it provides a structured process for engaging all stakeholders (such as decision makers) in valuing the "evidence" and identifying the action(s) required to enhance the proposal. This occurs at the assessment, negotiation and decision-making steps of HIA.

3.7 What is equity-focused health impact assessment?

Equity-focused health impact assessment (EFHIA) uses health impact assessment methodology to provide a structured way of determining the potential differential and distributional impacts of a policy or practice on the health of the population as well as on specific groups within that population and it assesses whether the differential impacts are inequitable. For example, an equity-focus relates to assessing whether identified differences in health such as higher Aboriginal infant mortality rates are the result of

factors that are avoidable and unfair i.e. they are potentially inequitable. (Mahoney et al., 2004) p.3)

Equity-focused health impact assessment seeks to:

- put concern for equity and the reduction of inequalities in health on the planning and policy agendas where it currently is not considered,
- provide a flexible, yet structured approach to routinely and consistently identifying and determining the possible impacts of policies and practices on different population groups, and
- provide a means for adding evidence about inequalities and the consequences of inequity into decision making processes at all levels of government. (Mahoney et al., 2004) p.3)

4. ABOUT THE HEALTHPACT EQUITY-FOCUSED HEALTH IMPACT ASSESSMENT

4.1 Rationale for an EFHIA of the Community Funding Program

To deliver the Board's strategic plan, the Health**pact** secretariat needed to assess the potential impact of the CFP on health inequalities in the ACT and identify what aspects (if appropriate) of the CFP processes could be changed to strengthen the equity focus of the program.

Since the 2003/2004 CFP round however, a new Board commenced (September 2003) and has made changes to the CFP – in part with a view to strengthening the equity focus of the program. These changes reflect the fact that the ACT Health Promotion Board sees itself as future oriented and forward moving organization. This reorientation was reflected throughout the EFHIA.

4.2 Screening

The screening step was undertaken by the Steering Group and based on a review of key policy documents including:

1. ACT Health Promotion Board Strategic Plan 2002-2005
2. Advertisement in print media for the 2003/2004 funding round of the CFP
3. Guidelines and application form for the 2003/2004 funding round
4. ACT Chief Health Officer's Report 2000-2002
5. ACT Health, Health Action Plan 2002
6. Service Agreement between: The ACT Department of Health and Community Care & the ACT Health Promotion Board, September 2002.

As part of the screening step the Steering Group found that the CFP has direct and obvious health impacts for the ACT community and the program seeks to address the social determinants of health as reflected in the:

- program areas of healthy people, healthy communities and healthy environments
- types of organisations that may apply for funding and receive funding eg. arts organisations
- types of projects that are funded under the CFP

The Steering Group also found that the **overall health impact** of the CFP is **potentially positive** for:

- community and government agencies who are successful under the program – they have improved resources to increase and improve the health promoting services available in the Act;
- those population groups who are the recipients of services, programs or projects developed and delivered by community agencies using funding from the CFP; and
- the ACT community overall – improved health promotion services/projects should contribute to improved health risk factors and hopefully an improvement in health outcomes, which in turn should contribute to a reduction in morbidity and mortality.

From an equity perspective, the CFP has **potentially positive health equity impacts** given the identified priority population groups are consistent with those groups or individuals as identified as experiencing inequalities (within Australia & internationally). The potential impact is that applicants will seek to develop health promotion services/projects that target the population groups who are identified as requiring targeted services and potentially those at risk of the most unequal health outcomes. The program documentation includes specific information concerning the social determinants of health so as to encourage applicants to address these issues. In addition, Health**pact** runs an application planning seminar as part of each funding round. Therefore it appear that the potential health and equity impacts would be positive and that a retrospective equity-focused HIA may be unnecessary, however the Steering Group also found:

- The CFP has a specific focus on addressing the social determinants of health and this does not equate with an equity focus. For example, projects funded under the healthy communities banner potentially still only benefit those who are already health advantaged.
- Current measures of the CFP do not contain information about the potential health inequalities impact(s) of the program.
- The priority population groups are groups within the population who may experience health inequalities but not necessarily inequities.
- Four of the seven focus areas of the CFP are focused on behavioural risk factors – increasing the chance that many funded projects will focus on individual behavioural

risk factors and therefore potentially widen the health inequalities gap by improving the health of those who are already well/health advantaged.

- Systemic change in health inequalities requires long-term effort, commitment and ongoing resources. Potentially the majority of projects funded through the CFP are for one year only – which may mean that the majority of grants and sponsorships are unlikely to have a long-term impact in addressing health inequalities.

The EFHIA Steering Group therefore recommended that an intermediate and retrospective EFHIA be undertaken to identify:

- the potential health equity impacts from the Community Funding Program using the outcomes of the 2003/2004 funding round as a focus; and
- how the equity focus of the CFP can be strengthened (if appropriate).

A more detailed report reflecting the key issues considered as part of screening step is available.

4.3 Goals and objectives of the EFHIA

Once the Steering Group had determined that a EFHIA of the Community Funding Program was appropriate the following goals and objectives were agreed upon.

The **overarching goal** of the EFHIA is: *to explore the potential health inequalities impacts of health promotion funding agencies using the Health**pact** EFHIA as a case study.*

The **goal** of the EFHIA is: to assess the impact of the ACT Health Promotion Board's funding decision processes on health inequalities in the ACT using equity-focused health impact assessment retrospectively.

The **objectives** of the EFHIA include:

1. Review the Community Funding Program processes for the 2003/2004 funding round (including all relevant funding policy documents, guidelines and applications) to determine whether they potentially have a differential health impact and if these differential impacts are potentially inequitable.

2. Assess whether different funding approaches used (sponsorships versus grants) have potentially different health impacts (eg. potential differential health impacts that may be inequitable).
3. Advise the Board about the outcomes of the EFHIA and make recommendations on how EFHIA could be incorporated into future funding processes and decisions for improving or influencing outcomes, to maximize health gains and minimise potential health impacts that may be inequitable.
4. Contribute to the development of the draft EFHIA framework by auditing the case study process in order to provide feedback to ACHEIA on the applicability of the framework.

4.4 Scoping

The key issues addressed as part of the scoping step by the Steering Group included:

- **formal confirmation**: of the goal, objectives, strategies and expected outcomes and timeframe for the EFHIA; and of the processes for conducting the EFHIA.
- **identification** of: the principles/values that would inform the EFHIA (in addition to equity); and all interested parties – those not on the Steering Group.
- **agreement** about: the proposed approach for engaging interested parties - eg. key informant interviews & workshop; the proposed search strategy for reviewing the literature; a process for valuing information collected as part of the EFHIA; and processes for reporting and accountability.
- development of agreed **definitions** for equity, health inequalities, HIA, health, health promotion and the agreed principles.
- **consideration** and discussion of a process for negotiation and decision making.

A more detailed report on the scoping step and the key outcomes is available.

5. IDENTIFICATION OF IMPACTS: WHAT WE DID AND MAIN FINDINGS

5.1 How information was collected on health impacts and equity issues

The purpose of this step is to collect information on the potential health impacts of the proposal that is being assessed and to develop a profile of the population groups potentially affected by the proposal.

In the EFHIA of the community funding program, profiling of the ACT population and information on potential health impacts of the program was collected through:

1. A review of the literature on health promotion (defined in it's broadest sense to include community development and an ecological view of health) and health inequalities – what does the literature tell us about the effectiveness of health promotion in addressing health inequalities.
2. A review and analysis of key ACT policy and program documents such as the Health**pact** Strategic Plan, the ACT Chief Health Officer's Report 2000-2002 and the Canberra Social Plan, 2004.
3. Interviews with key informants in the ACT to identify potential health inequalities impacts arising from the CFP.
4. A half day workshop with community and government organizations and consumers to identify potential health inequalities impacts arising from the CFP.
5. A content analysis of all applications (sponsorships & grants; successful & unsuccessful) received as part of the 2003/2004 funding round of the CFP.

The questions for the key informant interviews are at **Annex A** and the agenda for the workshop is at **Annex B**.

The findings from each of these sources is presented separately.

5.2 Findings from the literature review

The search strategy agreed as part of the scoping step was revised after an initial search of Medline and related databases yielded over 300 articles. An initial review of the articles highlighted different interpretations of the term 'health promotion', very little information on health promotion funding programs per se and very little on health promotion strategies to address health inequalities. Given the short timeframe available, the search of the literature was then revised to focus on known key references (usually identified through citations) and based on an earlier literature review undertaken in 2003 on health promotion and health inequalities.

5.2.1 The role of health promotion in addressing health inequalities

> *Health promotion professionals should feel optimistic that they can play a part by advocating 'upstream' strategies, including greater investment in research and policy development. In addition, they should continue to address the health needs of the most disadvantaged through their day-to-day service and practice. Progress can occur in reducing health inequalities.* ((Gunning-Schepers and Gepkens, 1996) p.104)

The literature reviewed indicated that health promotion makes an important contribution to addressing health inequalities. (Catford, 2002, Gunning-Schepers and Gepkens, 1996, Jennings and Scheerder, 2001, Mackenbach et al., 2002b, Mackenbach and Stronks, 2002, Oldenburg et al., 2000, Whitehead, 1995, Wilkinson and Marmot, 2003, Wise and Signal, 2000) There is evidence however that health promotion and public health practitioners encounter significant difficulties in translating commitments to reducing health inequalities (or political rhetoric) into actual practical, workable interventions. (Jennings and Scheerder, 2001, Arblaster et al., 1996):

> *Despite overall agreement that the reduction of social inequalities in health is a major priority, and that health promotion may significantly contribute to this goal, there is a lack of clear guidelines as to which policies and health promotion interventions are effective in reducing social inequalities in health. (Jennings and Scheerder, 2001)*

A review of interventions to reduce social inequalities in health (Gunning-Schepers and Gepkens, 1996, Arblaster et al., 1996), identified that 68 (69%) of the interventions used a

health education and/or health promotion approach. Of these, the programs that were most successful used a combination of information with structural and/or personal support (consistent with the health promotion principle of creating supportive environments). Also, this study highlighted that evaluations of interventions to reduce social inequalities in health were not undertaken systematically: usually due to little to no funding for evaluation; short intervention timeframes; a lack of relevant evaluation methodologies for assessing such interventions; and a lack of skill in using such methodologies. Another limitation of the evaluations was that they failed to measure whether the intervention made a difference to inequalities. (Gunning-Schepers and Gepkens, 1996)

The literature advocates that that health promotion has a contribution to make in addressing health inequalities at the midstream level (see Section 5.2.2). Measurement of health promotion initiatives that explicitly seek to address health inequalities should therefore be commensurate with this level – eg. improved health literacy or improved access for particular individuals or population groups experiencing health inequalities not measurement of a reduction in the health inequalities experienced by these groups – this needs to be measured at an upstream level. (White, 2004a)

A further issue is actual workforce capacity to address health inequalities on a day-to-day basis. A NSW project identified that a range of factors impacted on health promotion practitioners capacity to address health inequalities, including: a lack of organisational commitment and support for addressing equity; working in an environment where practitioners are forced to focus on lifestyle factors and changing behavioural risk and where there are limited resources for creating supportive environments; a strong focus on evidence based approaches using more traditional forms of evidence rather than relevant forms of evidence; and a focus on short term outcomes that are easily achieved (which are often low risk but also low in gain). (Vilshanskaya et al., 2003) Workforce capacity to address health inequalities should therefore not be assumed even where there is a system commitment to address health inequalities. (Gunning-Schepers and Gepkens, 1996)

5.2.2 Health promotion as part of an overall approach to reducing health inequalities

Health promotion by itself won't reduce health inequalities, however:

> *We cannot ignore the possible contributions of the healthcare system, because this is the only policy instrument within the power of health*

> *policy-makers, but health care interventions will never eliminate inequalities in health. We therefore need midstream solutions in the context of a broader strategy.* ((Mackenbach et al., 2002b)p.36)

The two important messages in this are that:

- health promotion initiatives to address health inequalities are best placed at the "midstream" level ie. Levels of exposure to unfavourable specific material living conditions, psychosocial risk factors and behavioural risk factors (Mackenbach et al., 2002b) – this means taking context into account; and
- health promotion (and other health initiatives) are most effective in addressing health inequalities when they are part of a broader system commitment to reducing inequalities eg. a government commitment. (Whitehead, 1995, Wilkinson and Marmot, 2003, Mackenbach et al., 2002b)

Third, while the health sector cannot change the "upstream" factors or root causes of health inequalities (eg. taxation policy, unemployment) the sector (including health promotion) does have an important contribution to make by advocating for change in these areas. (Catford, 2002, Wise and Signal, 2000, Mackenbach et al., 2002b) Advocacy for health issues and/or broader social issues that impact on health is a key platform of health promotion. (World Health Organisation, 1997)

5.2.3 Characteristics of health promotion initiatives in relation to health inequalities

Health promotion that focuses on behavioural or lifestyle factors with little attention to context, capacity and resources to act is of limited effectiveness in addressing health inequalities. In fact it may actually widen the gap and/or have a negative impact by reinforcing individual and/or population group's lack of control over factors in their lives. (ACT Council of Social Services Inc, 2003, Arblaster et al., 1996, Gunning-Schepers and Gepkens, 1996, Mackenbach et al., 2002b, Mackenbach and Stronks, 2002, Oldenburg et al., 2000, Whitehead, 1995, Wilkinson and Marmot, 2003) (Emmons, 2000, Kawachi and Berkman, 2000) The literature on sponsorships reviewed as part of the EFHIA (Holman et al., 1997, Corti et al., 1995) does not address issues of differential health impact but focuses on measuring success in replacing tobacco advertising at sporting venues with health promoting messages.

Health education and promotion programs that use a combination of information with structural and/or personal support (eg. addressing barriers to an individual and/or population group's capacity to act) (Arblaster et al., 1996, Gunning-Schepers and Gepkens, 1996) can make a contribution to addressing health inequalities. Where health promotion programs focus on priority health issues such as diabetes or cardiovascular disease and associated risk factors these programs should also address individual and/or population group capacity and opportunities to act eg. income, occupation, and living standards. Factors that enhance the effectiveness of health promotion in addressing health inequalities include: providing individuals and or population groups with support and resources to enable them to act on behavioural risk factors; using community development approaches; building capacity through strengthening communities and/or social capital; and improving access to essential facilities and services; and advocating for broader structural and macro economic or upstream change to address the root causes of health inequalities. (Oldenburg et al., 2000, Whitehead, 1995, Gunning-Schepers and Gepkens, 1996, Emmons, 2000, Kawachi and Berkman, 2000)

Settings based approaches are also recommended as one way of effectively addressing health inequalities through health promotion – in particular schools, neighbourhoods and workplaces (Acheson et al., 1998, Mackenbach et al., 2002b). Examples of such initiatives include healthy canteens, providing school dinners and/or fresh fruit at school. (Acheson et al., 1998)

> *When interventions are carefully targeted in workplace and residential settings, and when issues of social support and psychological health are also addressed, there is increased likelihood of improving the health of people in lower SES groups.* ((Oldenburg et al., 2000) p.490)

In relation to workplace health promotion it's important that such initiatives address issues such as locus of control, the type of work etc with a view to reducing stress and improving psychosocial health (Acheson et al., 1998, Mackenbach et al., 2002b, Wilkinson and Marmot, 2003, Whitehead, 1995, Oldenburg et al., 2000, Hogstedt and Lundberg, 2002). In Europe, it is clear that working conditions contribute to health inequalities in cardiac heart disease, mental health and musculoskeletal conditions but there are few programs focused on prevention and/or improving the work environment. Most workplace health

promotion initiatives however are about employers seeking to reduce ill health for the purposes of increased productivity and increased efficiency. Despite this there have been a few workplace programs implemented that show promise as one way of addressing this aspect of health inequalities using the workplace as a setting. (Hogstedt and Lundberg, 2002)

5.2.4 Universal and targeted approaches to health promotion

Universal health promotion approaches can potentially contribute to a widening of the gap because they usually favour the advantaged and/those people who have a greater capacity to act. (Emmons, 2000, Mackenbach et al., 2002b, Oldenburg et al., 2000) This suggests that as well as locating health promotion initiatives at the "midstream" level consideration also needs to be given to "targeting" of some health promotion initiatives. The literature on health inequalities however does not advocate targeted approaches per se or as the **only** route for addressing health inequalities. In fact, by only taking a targeted approach to health inequalities and/or health promotion there are potential risks such as:

1. a reduction in overall population health gains because people who are not most advantaged or most disadvantaged but in the middle may miss out and/or the health inequalities experienced by this group may in fact increase (Graham, 2004);
2. people who are the intended target group may not identify with the initiative and/or criteria and may not use the service or participate in the program; and/or
3. related to the former, targeted approaches may unintentionally stigmatize (Prattala et al., 2002) the intended recipients eg. as "most disadvantaged and in need" and may in turn result low uptake of the initiative by the intended target group.

The implication is that a balance of universal and targeted approaches is required to ensure that potential system gaps are covered. Initiatives to address health inequalities: need to be targeted sensitively and without creating stigma where the recipients are a specific group of people; and where the intended target group is the entire population or universal such initiatives should be designed in such a way that they are appropriate and accessible to all population groups.

Summary: literature review

- Health promotion can make an important contribution to the reduction of inequalities in health, particularly where:
  - interventions that use a combination of information with structural and/or personal support (eg. addressing barriers to an individual and/or population group's capacity to act) (Arblaster et al., 1996, Gunning-Schepers and Gepkens, 1996)
  - interventions are focused on addressing factors at the midstream level
  - practitioners advocate for change to factors at the upstream level such as taxation policy
  - there is long-term commitment to and investment in an intervention and overall program to reduce inequalities (Gunning-Schepers and Gepkens, 1996, Mackenbach and Stronks, 2002a, Mackenbach and Stronks, 2004)
  - interventions use a combination of information with structural and/or personal support (eg. addressing barriers to an individual and/or population group's capacity to act) (Arblaster et al., 1996, Emmons, 2000, Gunning-Schepers and Gepkens, 1996)
  - action takes place as part of a broader government commitment to reduce health inequalities.
- A combination of targeted and universal approaches is required.
- Settings based approaches are effective but greater investment is needed in workplace health promotion programs that address issues such as locus of control. (Hogstedt and Lundberg, 2002a) Health promotion interventions that focus on behavioural risk can increase health inequalities but if attention is paid to issues such as the setting, local context and the like, can make a contribution. (Macintyre and Ellaway, 2000, Whitehead, 1995, Mackenbach et al., 2002b)
- There is no information about the health inequalities impact of sponsorships.

5.3 Findings from review of key ACT policy documents

The following key documents were reviewed as part of the identification of impacts step:

1. ACT Chief Health Officer's Report 2000-2002
2. ACT Health, Health Action Plan 2002
3. ACT Health Promotion Board Strategic Plan 2002-2005
4. Chief Minister's Department. Building our Community. The Canberra Social Plan. 2004
5. ACTCOSS. Sustaining the Social Determinants of Health in the ACT. November 2003.

The review of key policy/strategy documents was undertaken to assist in developing:

- a profile of health inequalities in the ACT; and
- to identify action that is being taken or planned as a way of addressing health inequalities in the ACT

The first three documents were also reviewed as part of the screening step.

5.3.1 Health, inequalities and health inequalities in the ACT

The review of key policy/strategy documents indicates different perceptions about health inequalities and the action that needs to be taken and/or is being undertaken to address health inequalities. For example the Chief Health Officer's report portrays a community (the ACT) that is doing relatively well in terms of the social determinants of health.

> *Social indicators in the ACT are largely positive, with almost all of the indicators profiled for the ACT yielding favourable results, compared to the results for Australia and other jurisdictions …* ((Dugdale and Kelsall, 2003) p.9)

The only explicitly identified equity issue is that of major gaps in health outcomes between Aboriginal and non-Aboriginal people in the ACT. (Dugdale and Kelsall, 2003) People of Culturally and Linguistically Diverse (CALD) backgrounds are understood to belong to a relatively homogenous and settled population based on a 'country of birth' measure. The most commonly used bases for comparison within the CHO's report however are the ACT compared to the rest of Australia, gender and age. In terms of the social determinants of health (eg. housing, transport, employment, income) the ACT population is compared to

Australia with the result that the ACT is seen as doing well. (Dugdale and Kelsall, 2003) There is however no information about comparisons within the ACT – eg. between people who are unemployed compared to employed people.

Defining health inequalities in the ACT relative to the rest of Australia (Dugdale and Kelsall, 2003, Chief Minister's Department, 2004, ACT Health, 2002) can: create a perception that this affluence and good health is shared equally by all; render health inequalities invisible or less visible; and/or create less willingness to acknowledge (and document) the health inequalities that exist between and within groups. It is therefore harder to see the people who aren't benefiting from Canberra's affluence and the need for strategies to better meet their needs.

The other documents reviewed however provide a different picture of inequalities and health in the ACT.

> *While the ACT community as a whole enjoys good health, some people in the community experience poor health or do not have ready access to quality health care services.* ((ACT Health, 2002) p.8)

> *Canberra is a fortunate and prosperous community, yet there are significant levels of vulnerability and exclusion within the community. People's ability to be part of the society in which they live is not determined just by income, but also by poor health or lack of access to transport, or by inappropriate housing. During our consultations people often spoke of the exclusion of some Canberrans and felt that, although the general statistics for the territory were impressive, they sometimes conceal significant disadvantage.* ((Hudson, 2004) p.3)

This suggests that there are certain groups in the ACT who experience inequalities (ACT Health, 2002) and who potentially are not benefiting from health promotion initiatives funded as part of the Community Funding Program. (ACT Council of Social Services, 2003) People of CALD backgrounds are described as "vulnerable" in some instances for example, recent migrants and refugees on Temporary Protection Visas who are unable to access adequate housing or are homeless. (Chief Minister's Department, 2004) Other groups identified as a focus for action (targeted or otherwise) include: people with a

mental illness; working with the Aboriginal and Torres Strait Islander community for better health outcomes; people who have problematic drug and alcohol use; detainees' disadvantaged members of the ACT community; and population groups who are "vulnerable" to health problems linked to their socioeconomic status. (Chief Minister's Department, 2004, ACT Health, 2002)

Few if any of the policy documents reviewed define what is meant by "disadvantaged" or people who are "vulnerable" suggesting little consensus about which groups should be the focus of inequalities efforts. For example, strategies might be required to assist people who are "disadvantaged because of unemployment and/or their socioeconomic status and/or people who are "vulnerable" because of a chronic illness which limits their opportunities to work, generate income and be "included" in the ACT community. What's important however is the recognition that such differences between groups in the ACT exist and go beyond gender and age and a commitment to address these differences.

The ACT Health Promotion Board makes an explicit commitment to addressing the social determinants of health as part of its 2002-2005 Strategic Plan, beginning with a **vision** for *a healthy, vital, sustainable ACT community* where people:

- have access to safe, affordable, adequate shelter;
- a level of education that enables them to participate equitably in the community;
- an income that enables equitable participation;
- adequate, affordable health care;
- adequate, affordable and appropriate transport. (ACT Health Promotion Board, 2002)

The vision is underpinned by a **mission** to encourage the development of sustainable structures and opportunities that enable people to make and maintain healthy choices where the Board:

> *… will work to create opportunities for people to make healthy choices and support this by creating sustainable structures within the community that make it easy to sustain that new behaviour or choice.* ((ACT Health Promotion Board, 2002) p.8)

The Community Funding Program is one of the six strategies to achieve the Board's **goal** for the 2002-2005 triennium. (ACT Health Promotion Board, 2002) The Board's strategic plan is underpinned, informed by and consistent with the principles of the Ottawa Charter for Health Promotion and the Jakarta Declaration. As such the Board is keen to foster better practice in health promotion by funding projects that: use a comprehensive approach to health promotion ie. approaches that focus on addressing the factors in the environments in which people live in a health promoting way as well as approaches to change individual risk behaviours; are evidence based; support community action, are community driven and consultative; are participative; and use an intersectoral approach ie. working with agencies other than health

There are seven priority population groups in the CFP ranging from young people, people of Aboriginal and Torres Strait Islander descent through to people who are disadvantaged and people who are particularly at risk of poor health outcomes. (ACT Health Promotion Board, 2002) This list is reasonably comprehensive and indicates a specific commitment to targeting those population groups who potentially are least likely to benefit from mainstream health and health promotion projects. As identified in the screening step however it cannot be assumed however that all of these groups (eg. people from culturally and linguistically diverse backgrounds, young people) are automatically at risk of inequitable health outcomes as they are reasonably broad groups eg. young women who are not attending school are potentially more likely to have poorer health outcomes than young women attending school.

5.3.2 Action(s) and commitment(s) to act in the ACT

The Canberra Social Plan includes a commitment to a range of goals to be achieved over 5-10 years and strategies for achieving these goals. Of particular relevance is the goal for health which is to:

> *Improve the good health of the Canberra population and narrow the health gap between the general community and the poor and disadvantaged.* ((Chief Minister's Department, 2004) p.7)

Other strategies in the Social Plan include reducing unemployment, improving housing availability including "poverty proofing", decreasing inequalities in children's first five

years and improve transitions eg. from pre-school to school. (Chief Minister's Department, 2004)

The ACT Health Action Plan includes a commitment to Healthy People and one objective of this goal is promoting healthy living/wellbeing:

> *The Government will implement a range of strategies to assist members of the community achieve, maintain and improve good health and wellbeing. We aim to help people make, and accept responsibility for maintaining, healthy lifestyle choices … we will seek to reduce smoking, improve nutrition, address unhealthy alcohol consumption and promote physical activity… The needs of disadvantaged members of our community will be a particular objective of our health promotion efforts.* ((ACT Health, 2002) p.34)

Key priorities for action in promoting healthy living/wellbeing include: increasing the capacity to promote health in local communities through partnerships; development and implementation of a comprehensive cross-sectoral children's strategy; developing strategies and programs to better address issues relating to men's health – particularly young men; improving nutrition for vulnerable groups; development and implementation of healthy workplace programs, health promoting schools and facilitating community development in neighbourhoods; actively promoting physical activity particularly among children and older people; and working to improve the access of disadvantaged people and people with a disability to services. ((ACT Health, 2002) pp.34-39)

In terms of health promotion action/activity, the ACTCOSS report on the social determinants of health in the ACT highlights that it is not about knowing what to do in terms of healthy behaviours but people having the capacity and resources to act on this information:

> *Personal health is something that most participants believed they should have control over, but their experience of disadvantage reduced their capacity to exercise any control… Participants reported a range of social, economic and environmental barriers to achieving good health. They believed that those with more resources were able*

> *to better control their health.* ((ACT Council of Social Services, 2003) p.41)

In this context health promotion action would focus on enabling people to act.

Other (related) objectives of Healthy People in the ACT Health Action Plan include: improving mental health; working with the Aboriginal and Torres Strait Islander community for better health outcomes; and improving the health of detainees. (ACT Health, 2002)

The priorities for action as part of Healthy People in the ACT Health Action Plan together with the 5-10 goals and strategies of the Social Plan suggest a strong government commitment (across government) to decreasing the gaps in outcomes (health and social) between different groups in the ACT.

None of the documents reviewed however identify an overall government commitment to addressing inequalities and/or inequalities in health in the ACT.

Summary: review of key ACT policy documents

- Compared to the rest of Australia, the ACT is a relatively affluent society and the social indicators are largely positive.
- Within the ACT however there are clearly groups who are less fortunate including people of Aboriginal and Torres Strait Islander backgrounds, recent migrants and refugees, people with a mental illness and people who are 'vulnerable' to health problems linked to their socioeconomic status.
- There is divergence about whether people from CALD backgrounds experience health inequalities.
- The policy and program environment is receptive to addressing the needs of 'vulnerable' population groups and there are a range of action plans and strategies in place to address inequalities. For example, the Canberra Social Plan includes a commitment to narrow the health gap between the general community and the poor and disadvantaged.
- The different policy documents define 'disadvantage' and or people who are 'vulnerable' using different markers.
- However there is no overall government commitment to act to reduce health inequalities in the ACT.

5.4 Findings from the key informant interviews

Section 5.4 outlines the findings from the key informant interviews. The questions for the interviews are at **Annex A**.

5.4.1 Health inequalities in the ACT

The key informants were generally in agreement that the groups or individuals experiencing health inequalities in the ACT are: Aboriginal and Torres Strait Islander peoples; people with a chronic mental illness; and/or people who are disadvantaged where disadvantage was described in terms of employment/unemployment, level of income, homelessness etc. One informant thought that health inequalities in the ACT were not very different to elsewhere in Australia however others thought that health inequalities are different:

> *Health inequalities are better hidden in the ACT (because it is relatively affluent) but still present.*

> *People on low incomes – this impacts on all aspects of their lives, especially because they live in an affluent community where they become more isolated and are far less able to access services such as primary health care.*

Only two of the informants specifically mentioned people from a CALD background in relation to health inequalities and were each of a different view:

> *People from a culturally and linguistically diverse background – not really experiencing health inequalities – settled community.*

> *Other health inequalities include people who are … from culturally and linguistically diverse (CALD) backgrounds*

5.4.2 Addressing health inequalities

> *Health inequalities cannot be addressed by any one organisation…*

> *Best way to create a healthy community is to improve the health of the disadvantaged.*

Key informants were asked a range of questions about approaches to addressing health inequalities. In summary they identified four main ways that health inequalities could be addressed including:

1. improving access to mainstream services, ensuring direct and targeted service provision, taking a case management approach and having strong universal services;
2. changing attitudes to people who experience inequalities by challenging the 'vilification' and 'othering' of people;
3. working together through communities, whole of government and intersectoral approaches and specifically some informants stated that there is scope for working with other agencies on specific issues such as housing to better address the needs of people with a chronic mental illness; and
4. through system and organisational changes such as placing a greater emphasis on preventative work, developing legislative and policy frameworks to create a supportive and enabling environment in which to take action eg. the Social Plan.

5.4.3 Health inequalities and health promotion in the ACT

In terms of health promotion, key informants considered that health inequalities could be addressed by:

1. Broadening the focus of health promotion activity from sole risk factors to looking at the social determinants, a life-course approach eg. moving beyond physical activity or taking action in other ways – getting people active in their community.
2. Using settings based approaches such as communities, neighbourhoods, workplaces and/or schools.
3. Developing the capacity of organisations, particularly small organisations, to identify and obtain longer term funding for interventions and approaches.
4. Using targeted approaches to health promotion eg. smoking cessation for low income, disadvantaged communities
5. Funding larger projects with longer timeframes and using an "evidence based" approach (ie. what works) to working with disadvantaged communities – including asking the communities what it is that they want or will work.

One key informant stressed the importance of access to information about what is available to promote health believing that most people don't act in a health promoting way because of lack of information.

Key informants identified a range of positive and effective health promotion achievements within the ACT including: the active healthy cities program using a neighbourhood setting and community development approach; work in the area of physical activity; mass campaigns, particularly around nutrition; engaging young people in health promoting ways; healthy canteens; delivering information to people where they live, work and play eg. medical centres, schools, workplaces; and youth in services intersectoral work that is looking at decreasing gaps in services for youth.

There was concern however that: health promotion efforts have been successful because it has "tended to focus on easy to target groups"; there is not really much of a theme beyond physical activity in health promotion funded projects; and health promotion projects are not currently very strategic.

> *Health promotion is about doing something for the whole community but especially those most disadvantaged. In the ACT there has been lots of money spent in health promotion on grants such as … and/or activities such as putting blimps over festivals BUT it is not achieving health for all – only for some groups and it's promoting the ACT Government's commitment to health promotion rather than actually doing it.*

In terms of effectiveness and health inequalities, most key informants considered that: health promotion efforts at working with disadvantaged communities and/or specific population groups such as Aboriginal and Torres Strait Islander peoples, people who have a mental illness could be improved through better resourcing, follow up and targeting; there are much bigger health gains to be made by "doing the difficult stuff"; and that grants to "elite" sporting organisations and sponsorships or branding were of minimal effectiveness. Sponsorships were described by one informant as "politically savoury but not effective."

*5.4.4 Health**pact** and the Community Funding Program*

> *Lots of grassroots work – mainly on physical activity with lots of small grants to "active" organisations.*

With regard to Health**pact** and the Community Funding Program, key informants were also largely positive but had similar comments to make in relation to health inequalities. Health**pact** and in particularly the CFP were seen as making an important contribution to the ACT community – the program was described by one key informant as a "popular generic program" and as based on a "well recognised international model of health promotion". Key informants were generally clear on the purpose of the CFP and it is intended contribution to health promotion in the ACT citing the objective of the program as being "… to resource communities and community groups to undertake health promotion activities which is seen as a really worthwhile and effective approach".

Key informants were specifically asked to identify potential health inequalities impact(s) of the CFP and identified a range of positive and negative potential impacts which are listed in **Table 1**.

> *Would not recommend that the grants be abandoned.*

> *Hard to see new options – important to build on what exists and work to deliver more of a good service.*

Table 1. Potential impacts of the Community Funding Program identified by key informants

Potentially positive	*Potentially negative*
• The CFP is a funding base that organisations can call upon – this is essentially positive.	• The way that the CFP is administered means it has potential to be placed in areas that are ineffective ie. it funds projects that have unrealistic outcomes. • CFP as just another potential source of funding rather than resources for building health promotion capacity.
• CFP funded projects can be used as demonstration projects and made attractive to other markets/funders who then take them up and fund them in the longer term.	• The CFP may encourage linear thinking about funding sources eg. instead of looking at other potential and longer term sources of funding such as Westpac and/or using knowledge of corporate sector in developing three year business plans etc. Health**pact** can only do so much through the CFP.
• The program gets people involved and active in health promotion work rather than just slogans, branding or advertising.	• Application process for the CFP invites strength building so that those who are good at preparing applications and have the infrastructure to do this get funded rather than funding on strategic priorities.
• Funding community organisations to undertake health promotion is potentially positive because they are more likely to be working with disadvantaged groups and therefore potentially more likely to reach people who are marginalized and/or experiencing health inequalities.	• Communities are "addicted" to the small grants process. • CFP does a great job of improving the health of those who are already well. • Sponsorships are potentially negative (ie. because they are about branding, linked with "elite" sporting organisations etc) but have a place.

Key informants considered that the CFP was largely positive in intent and outcome and their comments about the potentially negative impacts of the CFP were made in the context of how the equity-focus of the program could be strengthened to enhance the contribution it makes to health promotion and health inequalities in the ACT.

> *Equity focus of Health**pact** funded projects is okay and getting better. The main problem is that good ideas and groups in need of a project and CFP funding are often those that don't get funding because the application is not good.*

Key informants also provided suggestions about some of the ways in which the program could be strengthened, including:

- At a detailed level – revising the application form for the CFP.

- Strengthening Health**pact**'s alignment with other health promotion stakeholders in the ACT such as the Health Promotion Unit in ACT health and Health Promotion Officers working in the community and primary care sectors.
- Looking more closely at the characteristics of proposed grants/sponsorships to ensure that they reflect evidence based practice, an emphasis on larger scale programs; and ensuring that the expected health promotion outcomes of the grant/sponsorship are realistic.
- Becoming more strategic in the areas of improving the behavioural risk for Aboriginal and Torres Strait Islander peoples and people who are chronically mentally ill.
- Using targeted outreach strategies based on priorities identified by Health**pact** and other health promotion stakeholders eg. Health Promotion Unit. This might include building on or linking with the strategies identified in the social plan.
- Building workforce capacity to address health inequalities through initiatives such as the NSW health promotion four steps to equity.

The key informants were not necessarily in agreement about ways of strengthening the program and/or its equity-focus.

In terms of Health**pact**'s scope to address health inequalities through the CFP and/or other initiatives, most of the key informants felt that efforts should be targeted at improving the health of the most disadvantaged: making progress with the groups who we know are not well and experience disadvantage.

Summary: key informant interviews

- Key informants were in general agreement that health inequalities existed in Canberra identifying Aboriginal and Torres Strait Islander peoples, people with a chronic mental illness, and/or people who are 'disadvantaged' as the main groups experiencing health inequalities in the ACT
- Key informants had very different understandings about the function and role of health promotion and therefore of the function and role of Health**pact**.
- Most informants:
  - identified a range of ways that health inequalities could be addressed through health promotion in the ACT including improving access to mainstream services, changing attitudes to people who experience inequalities, working together through communities, whole of government and intersectoral approaches, and through system and organisational changes such as placing greater emphasis on preventive work;
  - identified a range of positive and effective health promotion interventions in the ACT;
  - were concerned about whether health promotion was successful because it focused on the easy to target groups;
  - thought that the CFP was largely positive in intent;
  - found it difficult to identify alternative ways of delivering the CFP to strengthen the equity-focus; and
  - thought that the objective of a strengthened equity-focus for Health**pact** would be to focus on the most disadvantaged groups.
- Some specific concerns were raised about sponsorships.

5.5 Findings from the workshop

Section 5.5 outlines the findings from the workshop with potential applicants and consumers. The agenda and key issues discussed at the workshop are at **Annex B**.

5.5.1 Health and promoting health

Workshop participants were asked to identify what "health" means to them and a key factor that they think "promotes" health. For some participants "health" means independence defined as "Being able to get out and about." or "To be able to participate and enjoy society without concerns." For the majority of participants, "health" means wellbeing which was defined as "finding balance – mind-body-soul" or "Social, emotional, physical wellbeing" or "Happiness, quality of life, wellbeing". One participant felt that "Health is when a person is doing the optimum to live life (physically, emotionally, mentally) – full of vitality."

The majority of participants thought that healthy environments and communities were key factors in promoting health including: social support and networks; culture, information, services and access to services; connectedness, trust, inclusion and choice; and government policies and actions. One or two participants identified "healthy lifestyle eg. exercise" as important to promoting health. Several other participants also thought that service provision "promotes" health in terms of access and information, "enthusiastic health promoters" and continuity of services. Opportunity and/or independence were seen as important by one or two of the participants: "Security and not having to worry."

5.5.2 Health issues and inequalities in the ACT

> *… the ACT is a sanitized environment and groups such as recent migrants, refugees and their concerns are not visible.*
>
> *Because issues are diffuse (ie. geographically spread) they're not seen to exist or are regarded as individual instances…*

Stigmatisation and marginalization were identified as key issues impacting on people's health in the ACT. Poverty was identified as something that was not well-identified or visible and that this has an impact on people's isolation sometimes further compounding

their poverty eg. not choosing to access services. Some of the participants felt that some of the assumptions made about people's level of knowledge/ability to access information and cultural appropriateness acted as potential barriers to use of services. The ACT environment – cultural, physical/spatial and socioeconomic – was seen as directly relevant to health outcomes, particularly for people or groups who did not make up the "norm" ie. not affluent compared to the rest of Australia.

The physical environment of the ACT was identified as contributing to the lack of visible health inequalities because disadvantage was often geographically dispersed rather than clustering in specific locations. For example, one family receiving community housing assistance living in an area where all other families owned their own homes and/or were renting privately. On the other hand, some participants stated that because the ACT is largely an affluent society, people who experience disadvantage or chronic mental illness are stigmatized and marginalised because they are so apparently "different" to the rest of the population. Several participants also referred to the social isolation that results from being disadvantaged in a relatively affluent community.

Several participants considered that issues of disadvantaged were not well addressed in the ACT due to lack of long term services and acknowledgement of disadvantaged groups eg. public housing and flow through of problems. The concept of cumulative disadvantage linked to stigmatization and marginalization and visibility was also raised. Participants identified that getting the balance between and across groups is problematic eg. people who are affluent also experience health issues and may be "disadvantaged". They also considered that identifying the target population could sometimes lead to a segmented approach to service provision eg. what if you are not included or don't identify with the target population (affluent or disadvantaged?).

There was concern about stigmatizing or characterising groups – on what assumptions are groups identified as requiring specific equity action. In terms of accessing hard to reach groups, participants raised issues of accessing these groups and taking the time to build up trust. Linked to this are issues of urban transience and the impact of urban development on health – both physically and socially. In terms of timeframes – short terms grants were seen as raising difficulties because the outcomes base was much narrower.

In terms of specific groups for health inequalities action the groups or individuals most often mentioned included identified Aboriginal and Torres Strait Islander peoples and people with a mental illness. Older people were also mentioned. Finally some participants thought that mental health was seen by some as an issue that crossed SES and ethnic boundaries and an area for inequalities action but not necessarily on the basis of socioeconomic status.

5.5.3 Potential outcomes of the CFP from an inequalities perspective

Participants were asked to review some de-identified grant/sponsorship applications and consider the potential health inequalities impacts of the proposed grant/sponsorship. The potential outcomes and impacts – positive, negative and unknown – of the CFP from a health inequalities perspective as identified at the workshop are listed in **Table 2**.

Table 2. Potential impacts of the Community Funding Program identified by workshop participants

Potentially positive	*Potentially negative*	*Unknown*
Overall • Program provides funding opportunities that wouldn't exist. • Intrinsically positive. • Small programs can have a cumulative impact.		*Overall* • How do you build on projects? What is the next step? • Sustainability.
CFP process • Small, targeted grants with simple reporting requirements (compared to other agencies). • Flexibility – in administering the project ie. not tied into fixed objectives if things change. • Autonomy in project development. • Allows scope for innovation. • Process emphasizes community ownership.	*CFP process* • Funding may be limited to welfare organisations ie. may exclude non-health or welfare organisations • Having to "cobble together" grants in order to "buy" a staff member. • Small organisations may not have the capacity to apply eg. staff, knowledge, computer/printer, time and/or longer term planning in place to access funds easily. • Grant fatigue – flurry of activity, project ends, then organisations have to start over again. • Language of the application form may act as a barrier to those without knowledge of health promotion.	*CFP process* • Difficulties in applications may reflect difficulties with the application form. Needs to be simpler or does it?
Characteristics of projects • Allows alternative ways to address some health issues eg. through drama, art etc • "Piggybackjng" of message(s) using social activities. • Early intervention focus in grants. • Role models powerful. • Positive health messages.	*Characteristics of projects* • Short term: timeframe for grants is short. • Multilevel approaches – challenging. • Potential stigmatization of people who "behave in this way". • Potential stigmatization of groups by making them a "target" group. • Disempowering: in some instances the target group eg. children don't have control over their environment and can't change risky behaviours. Making them aware of risky behaviours without them	*Characteristics of projects* • Multi pronged programs have been shown to be effective but there is still a need for small grants. • How to build on the outcomes of small grants? • Do small grants fail to address the broader issues in the ACT? • Complementarity – are the smaller and larger grants moving in a similar direction? • Should small grants lead to other grants or just have larger grants? • Defining target groups – open to interpretation in

Potentially positive	*Potentially negative*	*Unknown*
	being able to act may create anxiety for the children. • Potentially didactic. • Assumptions about target groups – ie. they are all the same.	some applications eg. what is meant by "family"
Sponsorships • Allow links to reach broader groups. • May lead to increased awareness of groups, services & issues.		*Sponsorships* • Lack of evidence about social marketing campaigns. How does it work or not work? • What is the value of social marketing?
Other • CFP can facilitate partnerships (between organisations) and access to different groups or people in the community who are not otherwise accessible.		*Other* • Does it make a difference or for example do applicants just pay lipservice to objectives?

Summary: workshop

- Most participants understand health and promoting health as about more than traditional or behavioural risk factors, believing that health environments and communities were key factors in promoting health.
- Stigmatisation and marginalization were identified as key issues impacting on people's health in the ACT.
- Participants considered that issues of disadvantage were not well addressed in the ACT and that because the ACT is a relatively affluent society, disadvantage can remain hidden.
- The groups experiencing health inequalities included Aboriginal and Torres Strait Islander peoples and people with a mental illness. Older people and people from CALD backgrounds were also mentioned.
- Most participants saw the CFP as having a positive function and were uncertain/apprehensive about what a strengthened equity-focus might mean. For example, a potential positive is that there is funding for small programs which can have a cummulative impact but a potential negative is that small organisations have to put a lot of work into getting a small grant which they then 'cobble together' with other funding to buy a staff member. There was concern that moving to fewer and larger grants would remove the flexibility that the CFP currently offered with more and smaller grants.
- Participants did not have a definite view about sponsorships versus grants.

5.6 Findings from the content analysis of 2003/2004 funding round

Section 5.6 outlines the key (potential and actual) outcomes from the CFP based on the results of the content analysis of all applications (grants & sponsorships; successful & unsuccessful) received as part of the 2003/2004 funding round of the CFP.

5.6.1 Grants: overall findings

Some overall findings include:

- Over one third of the applications (36) for grants were unsuccessful.
- Only 14 (15%) applications were for multiyear projects – 71% of multi-year applications were funded.
- The highest amount of money sought and recommended for a grant was $37K; the highest amount of money sought for a grant was $58K but $15K was granted; and the least amount of money sought and recommended for a grant was $500.
- The highest amount of money sought and not recommended for a grant was $52.92K; and the least amount of money sought and not recommended for a grant was $1.4K.
- Several grants do not appear to be getting the funding required when successful. Nineteen successful applications were granted a different amount of funding to that sought – 18 were granted a reduced amount and one was granted an increased amount. This means that 32% of the successful applicants for grants received less than the amount they sought for the grant.
- Several organisations are also providing in-kind or actual funding from within their own organisation and/or a range of other sources.
- Six organisations were each successful in obtaining two grants in 2003/2004; one organisation was successful in obtaining three grants; and one organisation had two applications both unsuccessful.

5.6.2 Grants: funded compared to unfunded

5.6.2a Types of projects

In the 2003/2004 funding round of the CFP there were 12 project types for grants. The types or categories of projects funded provide a useful basis of analysis because they bring together the other criteria (relevant to equity) that can also be used to review funded compared to unfunded grants such as the target population groups and amount of funding sought. **Table 3** provides a summary overview of the number of applications received in each project category by funding status.

Table 3. Funded and Unfunded grants based on Project Type, 2003/2004 funding round

Project Type	Total received	Funded	Unfunded
1. Recreation	2	2	0
2. Sport	6	4	2
3. Drama	5	4	1
4. General Arts	2	1	1
5. Music	0	0	0
6. Festival	0	0	0
7. Capacity building within your community	21	9	12
8. Community development	15	9	6
9. Health Promoting Schools	15	12	3
10. Health Promoting Workplace	3	1	2
11. General Health	14	8	6
12. Other	9	6	3

Key points of relevance include:

1. The highest number of applications in the 12 project types was for projects focused on building capacity in the community – 21 applications.
2. Over half of the applications for projects that focused on building capacity in the community were unsuccessful at getting funding (12 out of 21).
3. A high number of health promoting schools projects were successful in obtaining funding - 12 out of 15 applications. Only 48% of the total funding sought for HPS

projects was granted. Of the HPS projects that were funded – 85% of the funding sought was granted. While this means that some projects were funded for less funding than that sought, the projects that were not funded sought quite large amounts of funding.

4. Only one of the three applications for a health promoting workplace project was funded and this project received less funding than that sought.

Within these project types there were some differences between funded and unfunded projects in all types except recreation (no unfunded grants). Examples of differences included:

- Applicants for unfunded grants sought larger sums of funding per annum eg. capacity building within your community, health promoting schools. In the Other category of projects however the unfunded projects sought less funding.
- Funded projects were better grounded in health promotion theory and/or practice eg. the categories of sport, general health and general arts.
- In the capacity building within your own community category, funded projects tended to build on target groups' experiences positively, had an education and training focus and seemed sustainable.
- In the drama category the projects that were unfunded didn't have a "health" message amidst the medium.
- The two unfunded projects in the health promoting workplace category focused on promoting mental health rather than physical health of workers in terms of targeting levels of stress and worker burnout. The key focus area of the funded project in this category was sun protection.

There did not appear to be differences between funded and unfunded projects in terms of priority population groups, key focus areas and/or multi-year projects within each of the project categories.

5.6.2b Key Focus areas

In the 2003/2004 funding round there were seven key focus areas (KFAs) for grants:

- 55 applications focused on one or more of the lifestyle areas (smoking prevention, sun protection, healthy nutrition and/or physical activity)

- 25 focused on safe communities in combination with other KFAs
- 51 focused on promoting mental health in combination with other KFAs
- 54 focused on community development in combination with other KFAs.

Table 4 provides a more detailed breakdown of how KFAs in terms of funded and unfunded grants and whether the focus of the project was single issue eg. smoking prevention only or a combination of several KFAs. There appears to be little difference between funded and unfunded projects on the basis of how applicants addressed KFAs. Most projects appear to have a focus however on more than one KFA, usually combining a behaviourally focused KFA with community development or safe communities.

Table 4. Funded and unfunded grants based on KFAs, 2003/2004 funding round

Key Focus Areas	Funded	Unfunded	TOTAL
13. Smoking prevention	1	2	**3**
14. Sun protection	0	0	**0**
15. Healthy nutrition	2	0	**2**
16. Physical activity	3	1	**4**
17. Safe communities	1	0	**1**
18. Promoting mental health	5	4	**9**
19. Community development	2	4	**6**
• **1+ of KFAs 1-4**	4	4	**8**
• **1+ of KFAs 1-4 AND 1+ KFAs 5-7**	25	13	**38**
• **1+ of KFAs 5-7**	13	8	**21**
TOTAL	**56**	**36**	**92**

5.6.2c Priority populations

There are seven priority population groups in the CFP. The application forms revealed widely different interpretations of the population group(s) that will benefit most from the proposed project. The information on priority population groups needs to be interpreted with caution as many applications did not specify a priority population and/or a primary target group – it had to be extrapolated from their application.

Table 5 provides a breakdown of the difference between funded and unfunded grants in terms of priority population groups. Most grants targeted more than one of the identified

priority population groups – therefore this will not add up to 92 applications. The priority population group that was the primary focus of the majority of applications was young people – over 40 applications identified young people as the target group. In terms of funded and unfunded projects, 69% of projects that had young people as one of their target were funded. By comparison 46% of projects that had groups other than the priority population groups or in addition to the priority population groups were not funded.

Table 5. Funded and unfunded grants based on priority population groups, 2003/2004 funding round

Key Focus Areas	Funded	Unfunded	TOTAL
1. Young people	33	16	**48**
2. People of Aboriginal and Torres Strait Islander descent	6	3	**9**
3. People from culturally and linguistically diverse backgrounds	6	5	**11**
4. People from low socioeconomic backgrounds	12	5	**17**
5. People with a disability	5	3	**8**
6. People who are disadvantaged	9	2	**11**
7. People who are particularly at risk of poor health outcomes	15	11	**26**
8. Other/Not an identified priority population group including health care providers, self-help groups who work with identified priority population groups, general community, older people, carers, parents and families, siblings	15	17	**32**

5.6.3 Sponsorships: some overall findings

Eleven applications for sponsorships were assessed as part of the content analysis, with the following results:

- Six applications were successful.
- Applications received were in the project areas of sport (3), general arts (1), music (1), festival (1), health promoting workplace (1), general health (3) and other (1).
- The successful applications were in the areas of general health (2), sport, general arts, music and health promoting workplace.

- Smallest amount requested for a sponsorship was $9K and the largest amount requested was for $31.35K – this was for the health promoting workplace sponsorship and they received $12K.
- The largest successful sponsorship was for funding of $25K and the lowest successful sponsorship was for $9.65K.
- Of the 6 successful sponsorship applications only one received less than the funding sought. This sponsorship was for a health promoting workplace.
- There were four applications for multi year funded sponsorships – 3 for 3 years and 1 for 2 years. Two were unsuccessful.
- The primary target group(s) for the sponsorship applications included – young people (7 applications); people with a disability (1 application); low SES/people who are disadvantaged (1 application); people 40 years plus; health professionals and industry; older people etc.

5.6.4 Sponsorships and grants

Table 6 highlights some potential areas of difference between sponsorships and grants. In terms of key focus areas, all sponsorships must address the KFAs 1 to 4 – smoking prevention, sun protection, healthy nutrition and physical activity. It is therefore difficult to compare grants and sponsorships from the content analysis on this basis.

Table 6. Sponsorships & grants some differences, 2003/2004 funding round

	GRANTS	SPONSORSHIPS
Success rate (funded versus unfunded)	61%	54%
Highest amount of $ sought	$58K	$31K
Highest amount of $ granted	$37K	$25K
Lowest amount of $ sought	$0.5K	$9K
Lowest amount of $ granted	$0.5K	$9.65K
Average amount sought (includes total amount sought for multi years)	$18.01K	$17.41K
Funded projects granted less than the amount sought	18 (32%)	1 (17%)
Applicants with additional funding (in-kind, sought or granted)	47%	100%
Number of multi-year projects	14 sought 71% success	4 sought 50% success

5.6.4 Overall health inequalities impacts of grants and sponsorships

The content analysis of applications for the 2003/2004 CFP funding round does not yield much information in terms of overall health inequalities impacts beyond some of that presented in sections 8.5.1 to 8.5.3. For example, information on the number of grants funded in each of the project types, the number funded in each of the key focus areas and/or the number of multi-year projects. The main reason for this is that the content analysis only tells us about what potential applicants intend to do not what actually happened ie. the actual impacts of funded projects or sponsorships.

Summary: content analysis

- The highest amount of money sought and recommended for a grant was $37K; the highest amount of money sought for a grant was $58K but $15K was granted; and the least amount of money sought and recommended for a grant was $500.
- In terms of funded versus unfunded grants and project types:
  - The highest number of applications was for projects focused on building capacity in the community – 21 applications;
  - Over half of the applications for projects that focused on building capacity in the community were unsuccessful at getting funding (12 out of 21); and
  - 12 out of 15 applications for health promoting schools projects were successful in obtaining funding and only one of the three applications for a health promoting workplace project was funded and this project received less funding than that sought.
- 55 of the applications for grants focused on one or more of the lifestyle key focus areas; 54 on community development in combination with other KFAs; 51 on promoting mental health in combination with other KFAs; and 25 on safe communities in combination with other KFAs.
- Over 40 applications identified young people as a target group and 69% of projects that had young people as one of their target groups were funded.
- The largest successful sponsorship was for funding of $25K and the lowest successful sponsorship was for $9.65K.
- 32% of grants and 17% of sponsorships received less funding than the amount sought.
- 71% of grant applications and 50% of sponsorship applications for multi-year projects were successful.
- Content analysis only provides limited information – eg. we don't know what the actual impacts are just the intention of applicants; and we don't know who is not applying.

6. ASSESSMENT OF IMPACTS: WHAT WE DID AND MAIN FINDINGS

6.1 Assessment – valuing and weighting the findings – what we did

During the scoping step the Steering Group agreed to collect information from each of the following five sources/cultures:

1. Individuals, clients or consumers – those people with direct exposure to the issue
2. People speaking on behalf or representing communities/groups etc – eg. action groups and experts
3. People speaking for or on behalf of specialised agencies/organisations eg. non government organisations when they are speaking as an organisation with expert knowledge
4. People speaking from a political and/or advocacy perspective – this can include non government organisations when they are advocating on a particular issue
5. Integrators – people who take a holistic view

Information collected from each group is distinct and separate from the other and valued equally. Usually information would be collected from eight people in each of the five groups however in this EFHIA information was not able to be collected from eight people in each group.

The Steering Group took this approach as they considered that "weighting" the different sources of information using a traditional evidence hierarchy such as that used by the NHMRC was not appropriate for assessing and/or weighting the type of information collected as part of this EFHIA (ie. there are likely to be few randomised control trials for health promotion interventions that also address health inequalities) (Petticrew and Roberts, 2003b).

Although a matrix was developed for case study sites to use in undertaking the assessment step of the EFHIA, the Steering Group did not use a matrix to map the potential health inequalities impacts as this did not meet their purposes. As part of the assessment step, the Steering Group met twice:

1. First to consider a draft report on the results from the identification of impacts step and discuss how best to map the findings as potential health inequalities impacts; and

2. Second to consider a further draft of the report on the findings, identify areas for recommendation, and how to progress the findings from the EFHIA (eg. presentation to Board etc).

At the second meeting, specific feedback was provided on the draft Health Inequalities Impact Statement and it was agreed that a postscript detailing the changes that the new Board had made to the CFP subsequent to 2003/2004 should be included with the EFHIA report once it was finalised.

Following presentation of the draft Health Inequalities Impact Statement to the Board in July 2004, it was agreed that the findings from the identification of impacts step should be reanalysed as the assumptions about how the different sources of information were reconciled were not as transparent as they could be. For example the information/evidence from the literature review concerning the attributes of effective health inequalities interventions was inadvertently given a greater weighting than the information collected from the other sources.

Examples or completed HIAs available on the key HIA websites (eg. HIA gateway and IMPACT sites) were therefore reviewed to identify if more detailed information about how information was weighted and valued during the assessment step was available. The main finding is that this step of HIA/EFHIA is not well documented in the field of HIA (London Health Commission, 2003) including:

1. there needs to be greater clarity about how different types of information are managed eg. whether stakeholder views are prioritized over the literature review (London Health Commission, 2003); and/or
2. more information is required about how divergent views/conflicting "evidence" is reconciled ie. how the "trade offs" are made.

The project team subsequently developed a matrix to illustrate – compare and contrast – the information provided by each source in response to the three questions that the EFHIA sought to address:

1. Is there a difference (ie. potentially different characteristics) between funded and unfunded grants/sponsorships?

2. Is there a difference between grants and sponsorships in terms of their potential health inequalities impacts?
3. What is the overall health inequalities impact of the Community Funding Program?

A completed matrix for each of the three questions is at **Annexes C-E**. The following sections (6.2-6.5) outline the results from analysis of the information in relation to each of the three questions.

6.2 Is there a difference between funded and unfunded projects?

The main sources of information used to answer this question are the content analysis, followed by the key informant interviews, the policy document review (eg. Health**pact** Strategic Plan and processes for the CFP) and the workshop. The matrix at Annex C provides a detailed breakdown of the information used to address this question.

The content analysis suggests that there is little difference between unfunded and funded grants. For example, within project types there is little difference between funded and unfunded projects with applicants seeking to address similar key focus areas, similar priority population groups and a similar number of multi-year applications. Looking across project types however, applicants who apply for projects in the recreation, drama and health promoting schools categories appear to be quite successful at obtaining funding; and applicants who apply for funding within the categories of health promoting workplaces (33% funded) and building capacity within your community (43% funded) are least likely to receive funding. Of the one health promoting workplace project that was funded, it received less funding than that sought.

Looking at the key focus areas, there was little difference between funded and unfunded applications for grants. The majority of applications received were for grants that addressed one or more of the four behavioural risk factors plus KFAs 5-7 (safe communities, promoting mental health and community development). Very few applications for a grant were for projects that addressed only one or one or more of the first four KFAs. It does however mean that the majority of funded projects (62.5%) in 2003/2004 addressed one or more of the behavioural risk factors.

In terms of priority population groups, 69% of grant applications that had young people as one of their target groups were likely to get funded. There was little difference however between funded and unfunded grant applications, 27% of the unfunded applications had young people as one of their target groups and 27% of the unfunded applications had population groups other than those identified.[1]

Both key informants and workshop participants indicated that because the CFP was based on applications, it was likely that those organizations who were good at writing applications (in part due to capacity and available resources) would get funded. This was seen as potentially negative because the projects that get funded may not be the priorities that need to be addressed. One or two key informants also identified the fact that funding was not allocated according to strategic priorities (such as health inequalities) as also potentially negative. By contrast another key informant noted that the CFP is based on an international and well recognized model of health promotion - therefore it is not unusual that funding is allocated largely based on the written application – this is consistent with health promotion practice.

From a contextual perspective, the objective of the program is to build health promotion capacity not address health inequalities per se and the criteria for the program (eg. KFAs) are developed on this basis. In terms of the strength based application process, it should be noted that Healthpact runs information sessions for new applicants as part of each funding round. In addition the project categories are consistent with health promotion practice – some are behaviourally focused but there are also settings based categories.

Other contextual information that needs to be considered however is the divergent opinions about the existence of health inequalities in the ACT and the need to address behavioural risk factors. The CHO's report suggests that apart from the gap in health outcomes between Aboriginal and Torres Strait Islander peoples and non-Aboriginal and Torres Strait Islander peoples, the ACT does well on the social determinants of health and even in behavioural areas such as physical activity. Counter to this is the view of the ACT Chief Minister and ACT Health that gaps exist beyond the differences suggested by the CHO's report and there are a range of activities that can be undertaken to address them –

[1] These applicants however may also have identified one or more of the priority population

beyond a behavioural risk focus. For example, investing in settings approaches such as workplace health promotion and improving public housing.

The **potential equity implications** that can be made in terms of funded and unfunded grants are limited. In part this is due to gaps or limitations with the information collected through the content analysis including:

- the characteristics of those organizations funded compared to those not funded are not known and this is important contextual information;
- we don't know who isn't applying; the actual outcomes of funded projects is not collected as part of the CFP;
- some applicants did not clearly identify either the KFA(s) and/or the priority population groups and this information was extrapolated based on their application; and
- there are no criteria/definitions with regard to priority population groups eg. "young people" or "disadvantage".

These limitations apply in relation to questions 6.3 and 6.4 where content analysis information is used.

Potential equity implications in terms of funded and unfunded projects are:

- Certain organizations are missing out on funding because of the criteria and lack of capacity to apply. The likelihood of this is *speculative* because it is not known which organizations are not applying and/or whether it is because of the criteria and/or lack of capacity.
- The organizations that are not getting funded and/or not applying are more likely to address equity issues or have equity based projects. This is probable to speculative because the content analysis highlights that there is a difference in success rates of types of projects funded – traditional projects such recreation and health promoting schools are more likely to get funded than health promoting workplaces and/or building capacity within your community. The *equity dimension* is that the literature review identifies settings based approaches in particular workplace health promotion as good practice and there is a commensurate ACT Health commitment to settings based approaches, including workplaces. The health inequalities impact therefore appears to

groups.

be *potentially negative* because so few health promoting workplace projects are funded. However we don't know why potential applications are not getting funding, nor the characteristics of the applicants – they may not be any more likely to have an equity focus. Therefore this potential impact is *probable* to *speculative* or unknown.

6.3 Is there a difference between grants and sponsorships?

The assumption in this question is that sponsorships have potentially negative and/or inequitable health impacts because they are usually universal in approach and because of their strong focus on behavioural risk factors. The main sources of information used to answer this question are the content analysis, followed by the key informant interviews and the workshop, and the literature review. The matrix at Annex D provides a detailed breakdown of the information used to address this question.

The content analysis suggests that there is a difference between sponsorships and grants, namely that:

- sponsorships have a lower success rate (54%) in getting funded in 2003/2004 compared to grants (61%);
- more grants were funded for multi-year projects (71% funded compared to 50%) although more applicants for sponsorships sought multi-year funding (36% compared to 15%); and
- only 17% of successful sponsorships were granted less than the money sought compared to 32% of successful grants.

In terms of the average amount of funding sought, it was approximately the same – about $17,000-$18,000 (this includes multi-year funding). However, in 2003/2004 the lowest amount sought for a project was $500 and the lowest amount sought for a sponsorship was $9,000. Also sponsorships focus on all four on the first four KFAs of the program – behavioural risk factors – and in 2003/2004 few of the sponsorships addressed any of the other KFAs.

The literature reviewed provides little information on sponsorships in relation to grants and/or health inequalities, as it mainly focuses on sponsorships as a way of replacing tobacco advertising with health promotion messages. (Corti et al., 1995, Holman et al.,

1997) If sponsorships are viewed as social marketing, the literature reviewed suggests that sponsorship has a place in health promotion but a limited place. (White, 2003) Key informants were definitive seeing sponsorships as having negative impacts and that sponsorships were more about "branding" than doing. Workshop participants, by contrast were less definitive: sponsorships are potentially positive in that they allow links to reach broader groups and may lead to increased awareness of groups, services and health promotion issues but the real impact of sponsorships was unknown. In terms of both grants and sponsorships, workshop participants queried if applicants just about paid "lipservice" to health promotion objectives as a way of getting funding.

Much of the contextual information presented in section 6.2 applies in relation to this issue for example, the focus of the CFP is on building health promotion capacity rather than equity per se and sponsorships/social marketing are part of this. In addition, all sponsorship applicants are required to address KFAs 1-4 as part of their application. Therefore it is not unusual that most funded sponsorships focus on the four KFAs that address behavioural risk.

In terms of limitations, the same limitations as identified in section 6.2 apply. An additional gap in information to note is that no literature on the difference between sponsorships and grants and/or the equity impacts of sponsorships/social marketing was identified or reviewed.

The **potential outcome** of having funding available for sponsorships as part of the CFP is that money is spent on activities that are largely focused on promoting healthy behaviour using a universal approach. The content analysis indicates however that sponsorship applicants are not necessarily more successful in obtaining funding than grant applicants – they have a lower success rate in obtaining funding and in terms of the overall program, the six sponsorships funded in 2003/2004 received a total of approximately $87,000 (not including the 2 multi year sponsorships that were funded) from the available money for the program in this funding round which was $ (Elizabeth). Of the sponsorships that were funded however only one received less funding than that sought and it was a three year project compared to the grants where 19 applicants received less money than that sought.

The **potential equity implications** that can be made in terms of a difference between sponsorships and grants include:

- Sponsorships however may have a *potentially positive* health inequalities impact because of their universal approach – according to the workshop participants, who were less certain about sponsorships having potentially negative health inequalities impacts. This view suggests that they do no harm and are an important part of an overall approach to health promotion in the ACT.
- The potential health gain achieved by approaches such as sponsorship is also *likely to be limited* because the health of people who are advantaged is likely to improve only minimally compared to the health of people experiencing health inequalities if funding was directed to meet their needs. As identified in 9.1 however, the potential for inequitable health impacts exists in grants funded through the CFP as well and this is because of the strong focus on behavioural risk factors in the program.
- Extrapolating from the literature reviewed because sponsorships focus predominantly on behavioural risk factors, are universal in approach and don't have to address contextual factors such as different population groups' capacity to act on the information, sponsorships could have a *potentially negative* health inequalities impact by widening the gap by improving the health of those groups who are already well. Sponsorships are not required to focus on factors outside of behavioural risk such as community development nor take a targeted approach and *may* be more likely to have a negative health inequalities impact than grants.
- The majority of key informants concur with the *potentially negative* health impacts of sponsorships based on the view that sponsorships funded through the CFP and using the current criteria are about "branding" or advertising rather than doing health promotion. Sponsorships are not considered particularly effective in terms of health promotion practice nor health gain. They are seen as focusing on the "easy to reach groups".
- Successful grant applicants are receiving less funding than that sought compared to sponsorship applicants. This may impact on the capacity of the proposed organisation to deliver the project effectively. Given the sponsorships are largely focused on behavioural risk factors and universal in approach, this is *potentially a negative* health inequalities impact because the funded grants may have greater

capacity to reduce the gap but may not being funded adequately thereby reducing their capacity.

6.4 What is the overall health inequalities impact of the Community Funding Program?

Tracking the overall potential health inequalities impact of the Community Funding Program is complex. It is apparent that the assumptions underpinning the program are well intentioned and positive but the objective of the program is not on strengthening equity and/or addressing health inequalities. Therefore the criteria (eg. KFAs and project categories) are not designed with an equity focus but with a health promotion practice focus (which may or may not include equity). There is also no information available through existing evaluation mechanisms about the actual health impacts of grants or sponsorships funded as part of the program. In answering this question information was drawn largely from all five sources - the literature review, policy review, key informant interviews, workshop and the content analysis.

The literature review makes a case for health promotion having a role in addressing health inequalities – at the midstream level and as part of an overall approach and/or commitment to addressing health inequalities. The literature review also provides information on the characteristics of "effective" health inequalities interventions and/or effective health promotion interventions to address health inequalities. This provides a context for assessing the potential health inequalities impacts of the CFP. Characteristics of effective or potentially successful interventions include – long term commitments to interventions, addressing the context in which population groups live and work (settings plus recognition of different capacity to act on health promotion messages), adequate funding for interventions, basing interventions on an "evidence" base which includes what the intended target group thinks about the issue, having structures in place to evaluate the intervention (linked to the need for adequate timeframes in order to measure a change) and building workforce capacity to address health inequalities. The literature review also highlighted that while targeted efforts are an important part of any approach sometimes universal strategies are required and/or more appropriate ie. to avoid stigmatization.

Much of the above is consistent with the other sources of information. The policy review illustrates that apart from the CHO's report, there is government recognition that health

inequalities exist in the ACT and a range of initiatives need to be implemented to close the gap. Examples include ACT Health's priorities for action such as health promoting workplaces, schools and neighbourhoods. Workshop participants and key informants also concurred about the nature and extent of health inequalities in the ACT – the main point of divergence being whether people from a CALD background experienced health inequalities. In terms of effective responses to health inequalities, the role of health promotion and in particular the contribution that the CFP could make there was divergence from the findings of the literature and policy review.

Among key informants the range of responses suggest that the potential health inequalities impacts range from limited positive impacts to no difference to potentially negative impacts (where the grants/sponsorships funded as part of the program benefit the most advantaged groups rather than the least advantaged groups in the ACT population). Some key informants did think that the way to address health inequalities effectively and through the CFP was to fund more large and long term projects that were based on "evidence" and a set of strategic priorities and fewer short term, small projects. One or two key informants felt that the equity focus of the CFP however was "just right" and/or improving and that it was potentially negative to see the CFP as **the** source of funding for health promotion to address health inequalities in the ACT. This is based on the view that the CFP provides funding for "seeding" grants so that short term projects can be funded and then picked up by other agencies or funding bodies who have greater capacity to fund the projects in the longer term. Most key informants thought that the objective of a strengthened equity focus for the CFP would be on targeting the most disadvantaged in the ACT community.

Within the community, feedback from workshop participants suggests that the program is perceived positively and as likely to have a positive health impact – there is potential for it to positively address the needs of people who experience health inequalities. Participants acknowledged that it was potentially negative to have to "cobble together" lots of small amounts of funding to create a position and for a project. However they also identified that lots of small projects could potentially have a positive cumulative impact. They also thought that changing the way projects were funded through the CFP could be potentially negative if the existing flexibility was lost – eg. there were more accountability

requirements for larger projects. The CFP was seen as an important source of funding that was easy to access and didn't exist elsewhere in the ACT system.

The content analysis supports perceptions about the number and size of projects funded through the CFP – there are very few multi-year/long term and large grants or sponsorships funded as part of the CFP. Putting the results of the literature review alongside the content analysis, the fact that the majority of projects (sponsorships or grants) funded as part of the CFP focus on one or more behavioural risk factors suggests that it has a potentially negative health inequalities impact. Yet, the majority of funded grants also address the KFAs of community development, safe communities or promoting mental health – very few funded grants only focused on behavioural risk.

The content analysis also highlighted the lack of specificity or clarity in defining priority population groups – this may have potentially negative impacts because those groups "at risk" within some of these broader population groups (eg. young people, people of CALD background) may still not be the recipients of projects. This issue links back to the suggestion that to strengthen the equity focus some funding should be allocated on the basis of strategic priorities and "evidence" about health inequalities in the ACT – ie. targeting. In terms of settings approaches, the content analysis highlighted that grants in the category of health promoting schools were more likely to get funded than grants in the categories of building capacity within your community and/or health promoting workplace. When reviewed against the literature and the ACT government commitments this is potentially negative.

The overall **potential health inequalities impacts** of the program include:

- From the perspective of other key informants and the workshop participants the CFP has the potential to have a *positive health* inequalities impact because:
    - it is a source of funding to undertake health promotion activity;
    - the program enables organisations to implement projects in a flexible way, without onerous accountability requirements;
    - sponsorships may be a good way of reaching a wide number of people in the ACT;

  - the purpose of the program is not to provide an ongoing source of funding but to “seed” projects that may get taken up by other programs; targeting of population groups as disadvantaged may result in stigmatization; and
  - many small, short term projects can have positive cumulative impact.
- From the perspective of the literature review, policy review, some key informants and the content analysis the CFP may have a *potentially negative* health inequalities impact because of:
  - its strong focus on behavioural health promotion and few projects funded in the settings categories other than health promoting schools;
  - possible further marginalization of groups who experience health inequalities because it is obvious that they are not “behaving in the right way” eg. people with a mental illness who continue to smoke;
  - lack of specificity from an equity perspective (eg. priority population groups and funding granted on the basis of successful application as opposed to equity priorities); and
  - the high number of short term, small projects versus long term, large projects for longer term gain.

Summary: assessment step

- There are few tools and limited guidance on weighting or 'valuing' evidence, particularly in valuing divergent data equally. A matrix was developed to address this issue.
- The limitations in the information collected mean that identified health inequalities impacts should be viewed as potential, probable and speculative rather than definitive.
- One of the potential equity implications in terms of **funded and unfunded grants** is that organizations are missing out on funding because of the criteria and lack of capacity to apply.
- In terms of **sponsorships and grants** include: sponsorships may have a *potentially positive health inequalities impact* because of their universal approach; however sponsorships may also be potentially negative or of limited impact because they don't have to address contextual factors and may only improve the health of those who are already well; and successful grant applicants are receiving less funding than that sought compared to sponsorship applicants, which may impact on the capacity of organizations to deliver the project effectively and is potentially a negative health inequalities impact because funded grants may have greater capacity to reduce the gap than sponsorships but may not be being funded adequately thereby reducing their capacity.
- Establishing the **overall health inequalities impact** of the CFP is complex and complicated by the fact that there is no information through existing evaluation mechanisms about the actual impacts of initiatives funded through the program. From the perspective of the key informants and workshop participants the CFP has potential to have a *positive health inequalities impact*. Using the findings of the literature review, policy review, some key informants and the content analysis, the CFP may have a *potentially negative health inequalities impact*.

7. DISCUSSION: MOVING FORWARD

The EFHIA highlighted that while health promotion and the Community Funding Program have an important role to play in addressing health inequalities in the ACT there is some divergence about – how effective current efforts are and what needs to be done to perhaps strengthen the equity-focus. This relates to views about the role of the program within the health promotion portfolio in the ACT and the broader ACT context.

The information collected for the assessment has some limitations, which have already been noted in Section 8, the main limitations being:

- there is no information collected on actual health impacts nor equity impacts of the CFP nor projects funded as part of the CFP;
- participants and key informants found it difficult to articulate issues in relation to "health impacts" and talked more about what they thought of the CFP and how it could be improved;
- the literature reviewed on sponsorships did not specifically address sponsorships compared to grants or from an equity perspective; and
- some of the KFAs and/or priority population groups identified in the content analysis had to be extrapolated from the application as the applicants had not completed this section.

Therefore the identified health inequalities impacts should be viewed as potential, probable and sometimes speculative rather than definitive. The results do highlight that there is scope to strengthen the equity-focus and to do this through greater clarity about the program objectives, focus areas, project types and priority population groups.

7.1 Strengthening the equity-focus of the Community Funding Program

Petticrew's article on evidence, hierarchies and typologies (Petticrew and Roberts, 2003a) highlights that issues such as appropriateness, acceptability and satisfaction need to be taken into account both in collecting information on health impacts and when reviewing/assessing the identified health impacts in terms of potential health inequalities impacts. Workshop participants and some key informants indicated that they were satisfied with the Community Funding Program. For example, they considered that a lot of small projects on a similar issue could have a positive cumulative impact over time, that

it was good to have a flexible source of funding for health promotion practice in the ACT and that they had flexibility in the way that projects funded through the CFP were implemented. Their stated satisfaction with the CFP and comments in relation to its appropriateness and acceptability need to be borne in mind when assessing the evidence and reviewing any changes to strengthen the equity-focus of the CFP. For example will the proposed changes be acceptable and/or appropriate?

The main area of divergence in terms of health inequalities impacts of the CFP is whether projects should be larger projects (particularly in relation to funding) and longer term. The literature and some of the key informants identify these as important characteristics of effective health inequalities interventions. Funding more large and longer term projects however leaves less funding available for smaller, short term projects in the CFP. The contrasting view is that the CFP provides a "launching pad" by seeding small projects which can then be "grown", picked up and funded sustainably or for the longer term by other organisations (government or corporate sector).

The potentially positive health impact in moving to more large grant allocations on the basis of strategic priorities is that organisations are more likely to be effective in addressing health inequalities over the longer term. The potential trade off however may be a loss of flexibility in the CFP and organisations (who have previously received funding) missing out on funding. The potential positive health impact through retaining the CFP as a funder of small projects with an equity-focus is community goodwill and short term positive health impacts such as increased health literacy. The potential trade off that is being made here is the longer term gains in health inequalities and potentially the health of certain groups of people within the population eg. people who require sustainable longer term funding for equitable health gain and who don't benefit from short term projects.

If the Board wishes to move to a model of longer term gain – ie. strengthening the equity-focus of Health**pact** and the CFP is about, addressing health inequalities through multi year projects funded on the basis of strategic priorities and fewer short term projects, then this would need to be done in a phased way and with a view to minimizing the loss of flexibility that might occur by funding projects differently. So some funding would be need to be allocated to small grants – as has occurred in the 2004/2005 funding round. If

the Board elects to retain the CFP as a seeding program, then it is important to build structures for funded projects to link into other larger, longer term and more sustainable sources of funding – otherwise the potential health equity impacts will be short term and lost quite quickly. This is where having an overview of larger, longer term funding sources in the ACT would be of use.

The other issues identified as part of the equity-focused HIA appear to be less contested and can be considered independent of the decision that the Board makes with regard to the overall equity objective of the CFP. These issues are covered in Sections 10.2.1 to 10.2.10.

7.2 Making an explicit commitment to addressing equity

There is currently no explicit commitment by ACT Health Promotion Board to address health inequalities through health promotion activity. The Board's strategic plan makes a commitment to addressing the social determinants of health but not specifically to equity. There is therefore no specific requirement for applicants to address equity issues through grants funded under the CFP nor for funding to be allocated on the basis of whether a proposal will address equity issues.

The findings from the EFHIA indicate that there is scope for the ACT Health Promotion Board to strengthen the contribution that it makes to health promotion in the ACT by making an explicit commitment to address equity through the CFP. This will require a change to the objectives, criteria and processes for the CFP. Based on the consultations and the need to be realistic about the outcomes of health promotion interventions to reduce health inequalities, the objectives of a strengthened equity-focus by the ACT Health Promotion Board might be:

1. Doing no harm – developing criteria and processes to reduce the risk that funded grants/sponsorships will widen the gap by increasing the health of those who are already well/health advantaged.
2. Funding health promotion grants and sponsorships to improve the health of the most disadvantaged in the ACT – those groups identified as experiencing health inequalities.

These objectives are complementary and interdependent. It is important to improve the health of the most disadvantaged in the ACT however this needs to be done through both targeted and universal strategies. To focus on improving the health of only the most disadvantaged in the ACT may: contribute to widening the gap because the health of people between the most and least disadvantaged may not improve (creating another gap): and/or miss those people who are identified as disadvantaged but don't identify as such and don't access targeted programs. It is therefore important to have a balance of targeted and universal health promotion interventions, where universal interventions are sensitive to issues of access and equity and available to all population groups/individuals.

7.3 A portfolio approach to health promotion

It is recognised that the ACT Health Promotion Board is only one of several stakeholders responsible for health promotion in the ACT (Board, ACT Health – Health Promotion Unit, ACT Health – community health, and non government sector). As identified, health promotion interventions are most effective when part of a broader commitment (eg. all of the ACT) to reducing inequalities. The Board however can play an important role in advocating for a strengthened equity-focus in health promotion within the ACT. The diversity of understandings about health promotion, its functions and expected outcomes expressed by the different stakeholders throughout the consultations suggests that there would be value in developing an overview of health promotion in the ACT. That is a statement that outlines who the stakeholders are, their respective roles and responsibilities – including addressing health inequalities as part of health promotion.

7.4 Sponsorships and grants

The potential health impacts about sponsorships are not definitive and there is a mix of views. The equity-focus of sponsorships could be strengthened however by:

- requiring attention to context as well as behavioural risk factors;
- funding sponsorships based on evidence such as an overview of the distribution of the health impacts of a particular risk factor within ACT eg. some groups doing better or worse on this issue and assessing whether this is fair or unfair, preventable or not so that the sponsorship can be designed to reach those population groups who most require it as opposed to the easy to reach target groups;
- overall, making sponsorships more appropriate and accessible as a universal strategy eg. providing accessible transport and/or transport to a sporting festival so

that everyone can participate; ensuring that there are actual accompanying strategies to assist people in acting on increased health knowledge or literacy of a particular issue – not assuming that everyone has the capacity to act; and

- maintaining a balance between sponsorships and grants because sponsorships are only a small part of effective, evidence based health promotion practice.

7.5 Settings approaches

The content analysis of different project types highlighted that there is a difference between funded and unfunded grants between project categories rather than within. Applicants in the health promoting schools category were the most successful at obtaining funding of those funded and received 85% of the funding sought. By contrast the project categories of building capacity within your community and health promoting workpaces were the least successful – the one of three health promoting workplace applications that was funded received a reduced amount of funding. By contrast the literature and the ACT government support a settings approach for addressing health inequalities. Further work is required on why the health promoting workplace category has such a low success rate.

7.6 Key Focus Areas of CFP

The findings of the EFHIA (particularly the literature review) indicate that health promotion interventions that focus on behavioural risk factors with no attention to the individual and/or population group's capacity, resources and/or opportunities (ie. context) potentially widen the health inequalities gap. Even health promotion interventions that focus on social determinants of health such as community capacity, may also widen the gap if individuals and/or population groups who are disadvantaged do not have the capacity, resources and/or opportunities to participate. Consideration of the social determinants of health does not automatically give rise to consideration of health inequalities. Such impacts are unfair and preventable because health promotion interventions can be designed so that individuals or population groups who would benefit can benefit positively.

Strengthening the equity-focus of health promotion programs therefore is about developing funding objectives, criteria and processes that ensure that health promotion interventions are funded with a view to: doing no harm - health gain is equitably shared among individuals and/or population groups; and actively improving the health of those who are

most disadvantaged in the population through tailored interventions and/or appropriately developed universal interventions.

Such an approach does not mean abandoning universal programs in favour of targeting – there needs to be balance between universal and targeted programs. Nor does it mean abandoning health promotion interventions with a focus on lifestyle factors - it is reasonable to expect that some component of health promotion funding will be spent on lifestyle factors for priority health issues such as diabetes and mental health – it is part of the core business of health. As the content analysis indicated, the majority of funded grants in 2003/2004 funding round addressed not only the behavioural risk factors but one or more of the other KFAs – which included community development.

Ways of minimising the potential for negative impacts include changing the percentage of funding allocated to grants with a lifestyle focus, reducing the amount of funding allocated to sponsorships and making more available to the grants program or by changing the ways in which grants with a lifestyle focus and sponsorships are developed eg. tailoring to ensure that the needs of those individuals and/or population groups who may be at risk of not benefiting equally from the grant/sponsorship are addressed. Tailoring or targeting of such grants/sponsorships however is dependent on a good understanding of those groups experiencing health inequalities in the ACT.

7.7 Priority population groups

In terms of potential impacts the content analysis highlighted that there was potentially no difference between funded and unfunded projects for priority population groups. Young people were the priority population group most often identified in both funded and unfunded projects. With the remaining priority population groups there was no difference between unfunded and funded projects.

The content analysis highlighted however that greater clarity is required in terms of the rationale for the priority population groups (why these groups?) and what is meant by each of the groups. For example does the priority population group of young people include 0-18 years or 0-12 years etc? From an equity perspective, not all young people will be a priority population group. If we are looking to strengthen the equity-focus, then greater clarity is required about young people who may be more likely to experience inequities in

health than those who won't. As well as young people there is a need for greater clarity around terminology in terms of "disadvantaged", what it means, why are people of low SES in a separate group and/or people at risk of poorer health outcomes? These three concepts potentially overlap.

Better information about why these groups are priority population groups would help applicants by clarifying what Health**pact** intends both by "priority" and an "equity-focus". This links to the idea of developing strategic priorities for allocation of funding which is dependent on having a shared understanding of health inequalities in the ACT and agreed strategies or priorities for health promotion – ie. Health**pact**'s contribution.

The EFHIA highlighted that there is consensus about three to four key groups who experience health inequalities in the ACT (ATSI, people with a mental illness, people with chronic drug abuse and/or people who are disadvantaged). However there was disagreement about whether people from a CALD background experienced health inequalities and this group is currently one of the priority population groups. There needs to be further discussion about the priority population groups in relation to health inequalities in the ACT with a view to reviewing the existing priority population groups and developing a set of clear definitions about what is meant for each of the groups from an equity perspective.

7.8 Developing strategic priorities for allocating funding

The current application process for the CFP potentially favours those applicants who are skilled at preparing a good application – which in turn is often dependent on resources (human and financial), infrastructure and capacity. Funding is not allocated on strategic priorities that have as their objective reducing health inequalities and/or strengthening equity through health promotion. However as previously noted the results of the content analysis have limitations because we don't know who is not applying and/or the characteristics of organisations who were funded compared to organisations who were funded – they may not be anymore equity-focused than current successful applicants. Also Health**pact** does run an information session for potential applicants and as has been noted equity is not the objective of the CFP per se.

To ensure a strengthened focus on equity however it is important that Health**pact** develop strategic priorities for allocation of CFP funding that are consistent with whatever equity objectives the Board develops for the CFP AND develops a process for allocating funding on the basis of the agreed strategic priorities. These priorities could be developed annually and/or every three years (consistent with the Board's strategic directions) and should be based on existing information about health inequalities in the ACT and in consultation with other key stakeholders (eg. non government organisations, ACT Health).

As part of this it is important however that proposals for funding through the CFP are assessed in terms of their potential effectiveness for addressing health inequalities. The literature review identified that health promotion or education programs that used a combination of information with structural and/or personal support were most successful in addressing health inequalities. The review also identified a range of limitations to interventions such as short timeframes for interventions (Gunning-Schepers and Gepkens, 1996) that could form the basis against which to assess potential applications, including:

- allowing an adequate timeframe for grants and sponsorships – meaning an increased number of proposals for three year projects;
- providing adequate funding for both implementation and evaluation of the grant or project; and
- having a systematic process for evaluation in terms of equity impact – does the proposal identify the measures by which the applicants will assess if they have made a difference to health inequalities?

The content analysis of applications for 2003/2004 indicated that there were very few applications for multi-year funding (either for grants or sponsorships). As identified however this is the area where there are quite different views among the sources of information about the potential health inequalities impacts.

One way of achieving grants with the potential for greater impact is to allocate a greater amount of the funding (both sponsorships and grants) to multi-year projects (three years). For example, work towards a 70:30 split of large to small grants. Large grants could be for applications of more than $5,000 and it will be a requirement that the projects take place over two (minimum) to three years and adequate funding is included in the project to

evaluate the potential equity impacts of the project. If the Board considers that this is an important component of their equity-focus it is suggested that Health**pact** take a phased approach to the introduction of such an approach (over three years) beginning with a 50:50 split and moving towards the 70:30 split.

It would be important however to retain capacity within the CFP to allocate small grants that take place over shorter timeframes. The consultations for the EFHIA revealed that while applications for small amounts of short term funding take up time and energy, they also provide flexibility to small community based organisations in meeting a range of important needs. The processes for CFP funding were seen as flexible and the CFP was identified as an important source of funding because most other grants programs require applicants to seek larger amounts of funding. Those consulted also identified that they often "cobbled" together funding from a range of sources to make one position. Retention of the small grants and development of a larger grants program, provides organisations with options about how they choose to fund a project. The "small" grants through the CFP could also be multi-year projects if so desired.

If the Board proceeds with a large:small grants split it is important that the application process is less onerous for those applicants seeking a small grant compared to those applicants seeking a large grant. For example, those applicants seeking large grants might be required to assess their draft project proposal with Health**pact** (as part of the workforce development seminars) in terms of potential health inequalities impacts. By contrast, applicants for small grants might be provided with a series of questions/checklist to assess their proposal for potential equity impacts prior to submission – an "equity lens" approach. The application form for the CFP could be revised to incorporate these questions.

7.9 Other issues

7.9.1 Addressing barriers for applicants

The requirement for organisations to have insurance coverage, may be operating as a barrier to small organisations in the ACT and preventing them from applying for funding through the CFP. This barrier may limit the potential pool of applicants who could meet the health promotion needs of those experiencing health inequalities in the ACT. It would

be useful for Healthpact to set up a process for working with potential applicants to explore potential solutions to issues such as insurance levels for example linking with other potential partner organisations. Other potential barriers for a wider number of applicants include workforce capacity to respond to the changes to the CFP eg. using an equity lens to assess the potential equity impacts of a proposal.

7.9.2 A revised application form – including an equity lens

The changes to the CFP in terms of objectives, key focus areas, priority population groups and criteria for assessment of applications and allocation of funding mean that the application form and information materials will need to be redeveloped. As part of the consultations, participants identified that the existing application form needs to be rewritten in plain English. Implementation of the changes to the CFP provide an opportunity to do this.

As part of the revision process, it would be worthwhile including one or two questions that encourage applicants (particularly for small grants) to consider the potential equity impacts of their proposal. These questions might be adapted and developed from a range of existing health impact assessment and/or equity audit tools, for example, the New Zealand "equity lens".

7.10 Taking a phased approach

The findings of the EFHIA highlighted key issues with respect to business practices and culture within Health**pact** and the processes for the CFP. At a broader level consideration needs to be given to the impact of changing both the focus and processes for the CFP. A key component of any change process is ensuring that the changes are and the intent behind the changes are communicated clearly - risk communication. For example, it is likely that if some of the suggested changes are made, that some peak community organisations who have previously been successful at obtaining funding through the CFP may miss out.

7.11 Building workforce capacity

Linked to the above is the issue of workforce capacity. It cannot be assumed that the workforce capacity to address equity issues exists in the ACT health promotion workforce – Health**pact,** ACT Health Promotion Unit, ACT Health and/or within community based

organisations. As well as clearly communicating the scope and intent of any changes to the CFP it will also be important to develop mechanisms for building capacity among potential applicants to better address equity issues. For example, a workshop for potential applicants to screen their proposals, assess the equity-focus, potential health impacts and further develop their proposals and/or funding a person to proactively identify key equity issues and groups and work with those groups to develop grant proposals. Finally there is also the issue of building workforce capacity to develop recommendations to take action on how to address health inequalities.

Summary: discussion

- Issues of appropriateness, acceptability and satisfaction need to be taken into account in both identifying and assessing potential health impacts. For example, workshop participants identified potential positive impacts such as the CFP provides an important flexible source of funding. Their stated satisfaction with the CFP needs to be borne in mind when assessing the evidence and reviewing any changes to strengthen the equity-focus.
- Information from the literature review and some key informants indicate that effective health inequalities interventions need larger amounts of funding and timeframes than currently occurs in the CFP. Funding for more larger, long-term projects leaves less funding for small, short-term projects in the CFP – potentially less flexibility and less opportunity for small organisations to act. The contrasting view is that the CFP provides funding to 'seed' small projects which can then be picked up or funded sustainably by other organizations.
- The **potential trade off** in moving to a program where the emphasis is on more large grant allocations is a loss of flexibility in funding for small organisations. Alternatively the **trade off** in retaining an emphasis on short-term, small projects is the longer term gains in health inequalities and potentially the health of certain groups of people within the population eg. those groups who don't benefit from short-term projects. This is a decision for the ACT Health Promotion Board.
- The EFHIA highlighted other ways in which the equity-focus of the program could be strengthened remembering that 'equity' is not the focus of the program per se. These other issues are less contested and include: greater clarity about the program objectives, focus areas, project types and priority population groups; changing the application form; building workforce capacity to address equity issues; and a specific commitment to addressing equity.

8. RECOMMENDATIONS

The following recommendations have been developed based on the assumptions that:

- Health**pact** wishes to strengthen the equity-focus of the Community Funding Program;
- Health promotion agencies (government, non-government and statutory) have a legitimate role in investing in grants programs that address equity;
- Strengthening the equity-focus – where at a minimum agencies should assess programs to ensure they do not increase the inequalities gap and wherever possible maximize the health gain for groups and/or individuals in the ACT who are disadvantaged;
- Equity is about addressing those differences that are preventable and unfair; and
- There needs to be a phased approach in the introduction of any changes which is accompanied by a communication and education strategy so that stakeholders are clear about the reasons for the change and because of historical patterns of funding.

8.1 The "big picture" – health promotion funding and/or grants programs

It is recommended that health promotion agencies (government, non-government and statutory):

1. Give consideration to investing in grants or funding programs that explicitly address equity, including the development of funding criteria that enable applicants to address equity issues. For example, where a health promotion funding and/or grants program focuses on priority health problems (eg. Diabetes) and/or associated risk factors (nutrition and physical activity), criteria should be developed to ensure that funded programs address:
   a. the wider social determinants of health that impact on behavioural risk factors such as the context(s) in which individuals, population groups and/or communities live, work and play (eg. income, occupation, housing type, location); and
   b. issues of equity of access and outcome for individuals, population groups and/or communities.

This recommendation is about health promotion agencies explicitly addressing equity in funding programs through both ensuring that funding programs don't make inequalities

worse (do no harm) and by funding grants/sponsorships that explicitly seek to improve health inequalities. It is more than just having equity as an underlying principle of a funding program.

8.2 ACT Health Promotion Board

It is recommended that the ACT Health Promotion Board:

2. Develop a statement that overtly articulates that Board's commitment to equity as a key objective of health promotion activities of Health**pact** and specifically the Community Funding Program, including:
   a. revised objectives for the CFP including equity as an explicit objective;
   b. revised key health themes, priority strategies and priority population groups for the CFP; and
   c. strategic priorities for the allocation of funding through the program.
3. Advocate for the development of a portfolio statement about "health promotion" in the ACT including an overview of the key stakeholders, their responsibilities and contribution to health promotion, and health promotion's role in addressing health inequalities. The statement needs to go beyond the existing Service Agreement and identify the role and contribution of:
   - Health**pact**
   - ACT Health Promotion Unit
   - ACT Health eg. Community Care Branch etc
   - Community and non-government organisations
   - Other government agencies in the ACT

8.3 Healthpact – Secretariat as the operational arm of the Board

It is recommended that the Health**pact** secretariat develop a system that reflects the ACT Health Promotion Board's priorities and explicit commitment to addressing equity through the Community Funding Program including:

4. Development of revised and/or new processes for the CFP to address the revised objectives for the program so that the majority of grants and sponsorships funded through the CFP have as their primary objective - improving the health outcomes of

disadvantaged groups and/or reducing the gap. The revised and/or new processes should include:

a. a set of strategic priorities developed in consultation with other key stakeholders (eg. non government organisations, ACT Health) and based on known health inequalities in the ACT;
b. revised criteria for applicants including project types, key focus areas and program areas;
c. revised and explicit definition of priority population groups eg. more specific about "young people";
d. revised application form that includes strategic priorities, revised objectives and criteria for the program, is written in plain English and includes a question about potential health equity impacts (an "equity lens"); and
e. a revised process for assessment and allocation of funding of grants to ensure funding is allocated on the basis of proposals that meet strategic priorities. Depending on the Board's agreed view about equity objectives for the CFP, consideration may be given to how funding is allocated for achieving a balance between the number of small, short term projects and large, longer term projects funded as part of the program.

5. Development and delivery of a capacity building/field development program to assist the ACT health promotion workforce and/or all potential applicants for the CFP in addressing equity issues eg. awareness raising workshop on equity, practical ways of addressing equity, using an equity lens and/or HIA. This should also include funding or allocating funding for an identified person to work proactively with the community and/or key groups in identifying health inequalities issues and responses, and in developing applications for a grant through the CFP.
6. Development of an implementation and risk management plan for introduction of the changes to the CFP including how to phase in the changes so as not to disadvantage applicants.
7. Develop a plan for evaluation and monitoring of the changes to the CFP including: information to obtain an initial benchmark of the number of projects that are funded; then information through monitoring to assess the change over time; and system that moves beyond process evaluation.

9. EVALUATION AND MONITORING OF EFHIA

As part of the EFHIA an evaluation of the EFHIA process will be undertaken after completion of the EFHIA. CHETRE will undertake the process evaluation in conjunction with the EFHIA Steering Group, as part of the Group's final meeting. It is proposed that the process evaluation be based on progress against the agreed goal, objectives and strategies. Sources of information include key documents developed as part of the EFHIA (eg. Screening Report) and minutes/notes from meetings of the Steering Group.

An impact evaluation of the EFHIA may be undertaken at the same time as the process evaluation depending on the status of recommendations arising from the EFHIA eg. how many of the recommendations have been adopted.

Following completion of the EFHIA, it will be the responsibility of the Health**pact** secretariat to:

- Monitor the Board's uptake of recommendations in the Health Inequalities Impact Statement
- Implement and monitor any recommendations endorsed by the Board
- Evaluate progress against the overarching goal of the EFHIA
- Evaluate the actual impacts that arise as a result of any changes to the Community Funding Program

With regard to evaluating actual impacts, it is recognized that the Health**pact** secretariat are not in a position at present to monitor the actual impacts arising from projects funded through the CFP. Currently funded organizations are required to evaluate their grant or sponsorship. Consideration needs to be given to whether all funded organizations are asked to report on a specific health inequalities impact indicator as part of their funding agreement. This issue requires further discussion particularly with regard to the sustainability of such a requirement.

10. CONCLUSION

Health promotion can make a significant contribution in addressing health inequalities and the EFHIA has demonstrated that there is scope to strengthen the equity focus of Health**pact**'s work in the ACT through the Community Funding Program. The objectives of this strengthened equity focus are twofold:

1. ensuring that grants and sponsorships funded through the CFP don't widen the gap – do no harm – making sure universal projects are sensitive and appropriate to the needs of those experiencing health inequalities in the ACT; and
2. having an explicit focus on addressing health inequalities by funding projects that seek to improve the health promotion outcomes for the most disadvantaged in the ACT.

This requires the ACT Health Promotion Board to explicitly commit to addressing equity through the CFP and mandate the Health**pact** secretariat to revise the CFP funding processes so that funding can be allocated in such a way as to achieve these objectives.

Given the findings of the EFHIA and subsequent recommendations have implications for audiences broader than the ACT Health Promotion Board it is also suggested that this report be widely disseminated to other agencies including other health promotion foundations and ACT Health.

11. POSTSCRIPT

The following postscript was developed by the Health**pact** Secretariat.

1. A review of the CFP administration processes was undertaken, which streamlined the funding system in order to encourage more groups to participate in the funding system.
    i. One cheque payment only, instead of two (enabling funded organisations to gain interest on the whole of the grant monies as well as reducing administration for the funded organisation)
    ii. Introduction of a streamlined, user-friendly evaluation system for 2004/05
    iii. More new applicant seminars (morning, afternoon and early evening)
    iv. External service provided to mentor groups and assist with writing applications, as well as addressing literacy issues.
    v. A new Field Development position in 2004/05 (external to the CFP assessment process) to mentor and build the health promotion capacity of the NGO sector.
    vi. A description of all projects funded is available on the Health**pact** website, to further build capacity.
2. The CFP assessment system developed policies, including funding full budgets and overtly implementing an Affirmative Action policy with Mental Health and ATSI population groups, as a strong strategy for breaking barriers.
3. The CFP piloted a new Small Project Community Funding Round (SPCFR) 2004/05 - under $5,000 grants for specific capacity building projects. The small project administration time frame of 4 months aimed to overcome the barrier of lengthy waits, that can be prohibitive for small groups.
4. The Board reviewed other areas of support to the CFP and dedicated a recurrent Research & Evaluation position in 2003/04 to increase NGO ability for evaluation and facilitate the establishment of the Health**pact** Research Centre for Health Promotion and Wellbeing.
5. The CFP's sponsorship component was closely reviewed to increase capacity building opportunities. This included:
    i. a dedicated health promotion development officer position trialled in the NGO sector 2004-05

ii. no new partnered sponsorships in 04/05, as all sponsorships applications were able to be delivered as a grant (with possible assistance from the HPDO in some cases).

iii. ongoing commitment to sponsorships to continue the investment as a universal health promotion intervention.

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ANNEX A: Questions for Key Informant Interviews

Purpose of key informant interviews

We are interested in your views on the potential contribution of the Health**pact** Community Funding Program to addressing health inequalities in the ACT and how current practices could be changed or strengthened. Background information about the equity-focused health impact assessment (EFHIA) of the Health**pact** program has also been provided together with information on the Community Funding Program – this information is to assist you in responding to some of the questions, particularly questions 1 and 5.

I would like to start off with some general statements and then focus in on Health**pact**.

1. What do you think are the main health inequalities in the ACT (using our definition – see background information)?

2. How do you think health inequalities can most effectively be addressed?

3a. In terms of health promotion: What do you see is the role of health promotion's programs and activities in addressing health inequalities? Can you tell me a little about the range of health promotion programs in the ACT?

3b. What health promotion initiatives in the ACT do you think are most effective in reducing inequalities? Why?

3c. What health promotion initiatives in the ACT do you think are least effective in reducing inequalities? Why?

3d. Are there any health promotion programs you would like to see developed in the ACT to address health inequalities?

4. What do you know of the work of Healthpact?

5. What do you know about the Healthpact Community Funding Program?

6. What are the potential health inequality impacts (both positive and negative) of the Healthpact Community Funding Program? Try to give specific examples?

7. Do you think the equity focus of the Community Funding Program could be strengthened? How?

8. If a commitment was made to strengthen the equity focus of the Community Funding Program would you recommend that it focus on:
   a. Improving the health of the most disadvantaged groups in the ACT; or
   b. Reducing the health gaps between the most and least disadvantaged in the ACT; or
   c. Addressing the association between socioeconomic position and health across the population?

ANNEX B: Agenda for Workshop

HEALTHPACT COMMUNITY FUNDING PROGRAM
Workshop
Friday 26 March 2004, 9.30am-2.30pm

Facilitator: Sarah Simpson, Centre for Health Equity Training Research & Evaluation (CHETRE)

Small Group Work Facilitators:

1. Louise Eagar, Program Manager, Community Funding Program, Health**pact**
2. Elizabeth Gaukroger, Program Manager, Research & Evaluation, Health**pact**
3. Ben Harris-Roxas, Research Officer, CHETRE

9.30am	**Registration & Graffiti Wall**	Sarah
9.50am	**Introductions**	All
10.00am	**About the workshop** (presentation)	Sarah

- Why we're here
- Health impact assessment & equity in health
- About the Community Funding Program & context of health promotion in ACT

10.15am	**What does health mean? What promotes health?**	All

- Different meanings of health & what promotes health (5 mins - discussion)
- Full Monty – excerpt from video (20 mins)
- Health issues in the Full Monty (5 mins - discussion)
- Health in the ACT & promoting health in the ACT (20 mins - presentation & discussion)
- Potential grants/sponsorships to address these issues (10 mins - brainstorm)

11.15am	**Short break**	
11.25am	**Identifying outcomes & impacts of potential health promotion grants/sponsorships funded through the CFP**	All

- Explanation of task (5 mins) (Steps A & B)
- Small group work to identify the potential outcomes & how they impact

on health (25 mins)

- Healthy people (Louise)
- Healthy communities (Elizabeth)
- Healthy environments (Ben)

12.00pm **Lunch**

12.45pm **Identifying the nature of potential health impacts** All

- Small group work continued to identify (30 mins) (Step C)
  - Nature of potential health impacts (positive & negatives)
  - Are different groups affected differently & how?
  - Evidence & severity of potential health impacts
- Feedback from 3 groups (35 mins including group discussion)
- Strengthening the potential positive & minimising the potential negative (group discussion 15 mins)
- Priorities for action (group discussion 10 mins)

2.15pm General feedback & questions All

2.30pm **Close**

ANNEX C: Assessment of difference between funded and unfunded grants

SOURCE OF INFORMATION				
Literature Review	**Policy Documents**	**Key Informant Interviews**	**Workshop**	**Content Analysis**
No information	*Information about the CFP eg. application form* • Four of the seven key focus areas (KFAs) are on behavioural risk factors. • Ten project types including settings projects, community development. • Assessment of applications not undertaken using strategic priorities but a panel – who decide based on the applications submitted in each category and the criteria.	• Strength based application process – organizations good at writing applications get funded. (M) • Funding not allocated on the basis of strategic priorities such as health inequalities. (L) • CFP is based on a well recognized and international model of health promotion practice. (L)	• Strength based application process. (M)	• 39% of the applications for grants were unsuccessful • 14 applications for multi-year grants – 71% were funded. • No real difference in project type between funded & unfunded. • Recreation, sport and drama – higher number of projects funded out of applications received. • Building capacity within your community and Health promoting workplace – poor rate of getting funded – 43% & 33% respectively. • Recreation and Drama – good funding success – 100% & 80% respectively. • Health Promoting Schools quite successful at getting funded – 67% and of those that were funded received 85% of the funding sought. • Key Focus Areas – no real difference between funded and unfunded. Majority of projects address at least 1 of the four behavioural KFAs plus KFAs 5-7; followed by projects that address KFAs 5-7. Very few projects funded or unfunded that only sought to address one KFA or the behavioural KFAs only. • Priority population groups – most applicants targeted one or more of the priority groups. 69% of projects that had young people as one of their target groups were funded. • In terms of total funded versus unfunded – 33% of projects that had young people as one of their target groups were funded.
GAPS IN INFORMATION: LIMITATIONS				
• Characteristics of organizations who were funded compared to characteristics of organizations who weren't funded eg. were the larger non-government or				

peak NGOs funded more than the small, community based NGOs? • Actual outcomes of the funded projects – there is no mechanism for linking the outcomes/evaluation results from projects back into Healthpact nor information about equity impacts. • Who isn't applying and what ideas are potentially not being considered for funding. • Some applicants did not clearly identify either their KFA and/or priority population group(s). In terms of the priority population groups, often had to extrapolate. In addition some of the categories had potential for overlap eg.young Aboriginal and Torres Strait Islander peoples; people who are disadvantaged could also be people of low SES – not clear how these categories are defined and/or how they are understood by applicants. Where specific reference was made to SE status, this was included as a category. • Also the categories for priority population groups are fairly broad eg. young people – not all young people are disadvantaged or "at risk".
CONTEXT
• Application for funding under the CFP is fairly standard in terms of being application driven and is based on other models of health promotion practice. • Main objective of the CFP is to build health promotion capacity not to address equity issues per se. • Health**pact** runs a workshop for new organizations on preparing applications etc as part of the funding round process. • ACT doing well on behavioural risk factors – according to CHO's report – and focus of action may be better targeting of initiatives in Canberra. • Strong government commitment to addressing inequalities/gaps – Canberra Social Plan & ACT Health Action Plan. A priority for action in terms of working towards healthy people is a commitment to taking a settings approach to health promotion – neighbourhoods, schools and workplaces.
EQUITY IMPLICATIONS
• Strength based application process: Projects that could address equity issues may not be getting funded because organizations that might do this type of work may not be getting through the application round due to limited capacity to apply. • Criteria for CFP applicants: organisations that might be interested in addressing equity issues may not be applying for funding because equity per se is not mentioned in key documentation such as the advertisement calling for funding, the application form etc. • Behavioural risk factors: from a health inequalities perspective the literature suggests that a focus on behavioural risk factors such as smoking cessation or physical activity potentially widen the gap where they focus only on the behavioural risk and not the context in which individuals live and/or assume all individuals have the same capacity to act to change their risk. • Projects that have young people listed as priority population group have a strong chance of getting funded (66%) – this has potentially positive and potentially negative implications.

L = Two or less key informants mentioned this; or few workshop participants raised this issue.

M = Three or more key informants mentioned this; or half or more of the workshop participants raised this issue.

F = Four to five key informants mentioned this; or most of the workshop participants raised this issue.

ANNEX D: Assessment of difference between sponsorships and grants

SOURCE OF INFORMATION				
Literature Review	**Policy Documents**	**Key Informant Interviews**	**Workshop**	**Content Analysis**
• Only information available is about sponsorships in terms of whether it makes a difference in replacing tobacco advertisements with health promoting messages. (Corti et al., 1995, Holman et al., 1997) • Sponsorship as social marketing has a place in health promotion but limited. (White, 2003)	No information	Majority: • essentially viewed as negative in impact • branding rather than doing health promotion	*Majority – positive, negative & uncertain* • Allow links to reach broader groups. • May lead to increased awareness of groups, services & issues. • • Unknown impact – is sponsorship really effective? • Both grants and sponsorships – applicants could just be paying "lip service" as a way of getting funding to do a project that's not really health promotion.	Differences: • Sponsorships have a lower success rate 54% compared to 61% for grants. • More grants funded with multi-year projects than sponsorships. • Sponsorships focused on four behavioural risk KFAs – compulsory. • Average amount sought for sponsorships similar to grants but sponsorships have higher lower amounts of funding sought. • Priority population groups – young people the majority in both grants and sponsorships. • Remaining 34% with sponsorships that got funded – not priority population groups.
GAPS IN INFORMATION: LIMITATIONS				
• Characteristics of organizations who were funded compared to characteristics of organizations who weren't funded eg. were the larger non-government or peak NGOs funded more than the small, community based NGOs? • Actual outcomes of the funded projects – there is no mechanism for linking the outcomes/evaluation results from projects back into Healthpact nor information about equity impacts. • Who isn't applying and what ideas are potentially not being considered for funding.				

- Some applicants did not clearly identify either their KFA and/or priority population group(s). In terms of the priority population groups, often had to extrapolate. In addition some of the categories had potential for overlap eg.young Aboriginal and Torres Strait Islander peoples; people who are disadvantaged could also be people of low SES – not clear how these categories are defined and/or how they are understood by applicants. Where specific reference was made to SE status, this was included as a category.
- Also the categories for priority population groups are fairly broad eg. young people – not all young people are disadvantaged or "at risk".

CONTEXT

- Application for funding under the CFP is fairly standard in terms of being application driven and is based on other models of health promotion practice.
- Main objective of the CFP is to build health promotion capacity not to address equity issues per se.
- ACT doing well on behavioural risk factors – according to CHO's report – and focus of action may be better targeting of initiatives in Canberra. (Dugdale and Kelsall)
- Sponsorships required to address all four of the KFAs for behavioural risk factors – smoking cessation, healthy nutrition, sun protection and recreation.
- Strong government commitment to addressing inequalities/gaps – Canberra Social Plan & ACT Health Action Plan. A priority for action in terms of working towards healthy people is a commitment to taking a settings approach to health promotion – neighbourhoods, schools and workplaces.

EQUITY IMPLICATIONS

- Strength based application process: Projects that could address equity issues may not be getting funded because organizations that might do this type of work may not be getting through the application round due to limited capacity to apply.
- Criteria for CFP applicants: organisations that might be interested in addressing equity issues may not be applying for funding because equity per se is not mentioned in key documentation such as the advertisement calling for funding, the application form etc.
- Behavioural risk factors: from a health inequalities perspective the literature suggests that a focus on behavioural risk factors such as smoking cessation or physical activity potentially widen the gap where they focus only on the behavioural risk and not the context in which individuals live and/or assume all individuals have the same capacity to act to change their risk. Sponsorships may potentially increase the gap because only required to focus on behavioural key focus areas not on context.
- Projects that have young people listed as priority population group have a strong chance of getting funded (66%) – this has potentially positive and potentially negative implications.

ANNEX E: Assessment of the overall potential health inequalities impact of the Community Funding Program

SOURCE OF INFORMATION				
Literature Review	**Policy Documents**	**Key Informant Interviews**	**Workshop**	**Content Analysis**
• Behavioural risk factors – potential to widen the gap – if no focus on context.. • Balance of universal versus targeted. Important not to stigmatise in targeting nor to allow mainstream services to not address health inequalities. • Health promotion and the health sector at midstream level and part of an overall commitment to addressing health inequalities. • Health promotion responsibility to advocate for change in upstream factors eg. unemployment, education, housing etc • Settings based approaches potentially positive in particular – schools, workplaces and neighbourhoods/communities. Workplaces particular area for activity because area where intractable inequalities exist – focus on increasing sense of control, meaningful work etc • Longer time frames, adequate funding &	*Health inequalities in ACT* • Health inequalities exist in the ACT if look at differences between groups and beyond gender. (ACT Health, 2002, Chief Minister's Department, 2004, Hudson, 2004) • Divergent view – ACT doing well on social determinants of health and main arena for action in on gaps in health outcomes between Aboriginal and Torres Strait Islander peoples and non Aboriginal and Torres Strait Islander peoples. (Dugdale and Kelsall, 2003) *Commitments to act:* • ACT Social Plan – redressing the gaps in health outcomes, poverty proofing, improving educational attainment and a focus on early childhood. (Chief Minister's Department, 2004) • ACT Health Action plan priorities for action – reducing gaps, settings based approaches (workplaces, schools &	The key informant interviews highlight divergent views about the impact of the CFP. *Potentially negative* (M) • Lots of small projects focused on physical activity going to "active" organizations/organizations good at writing grants. • Grants going to "elite" organizations. • Sponsorships not effective – talking or advertising a commitment to health promotion but not acting on it. • Funding not allocated based on strategic priorities and invites "strength building". • Communities "addicted" to small grants process. • Focused on easy to target groups rather than those most in need or most disadvantaged. • Inadequate funding of projects due to scoping, size of projects & timeframes too small.	*Potentially positive* • A source of funding to call upon. • Flexible funding program – not onerous in requirements • Number of small projects can have a cumulative positive impact. • Use of different mediums (eg. arts, community initiatives, schools) to get a health promotion message across – positive. • Sponsorships – provide a medium for delivering health promotion messages to wide number of people. *Potentially negative* • Having to "cobble" together lots of small grants to buy a person for a project. • Timeframe of one year – short in terms of capacity to keep applying. • Organizational capacity to apply may be limited. • Challenge with targeting appropriately and non-stigmatising way. • Multilevel approaches –	• Settings based approaches limited to schools – low success rate with workplace grants. • Capacity building in community project category – low success rate. • Sponsorships focus on behavioural risk KFAs only. • 32% of successful applicants for grants received less than the amount of funding they sought for the grant. • Few multi-year applications in either grants or sponsorships – only 15% of applications reviewed sought funding for multi-year projects. • Younger people are the most nominated priority population group by applicants for both grants and sponsorships. • Grants & sponsorships that nominate younger people as one of their target groups get funded. For example 33% of grants funded had younger people as one of their target groups.

SOURCE OF INFORMATION				
Literature Review	**Policy Documents**	**Key Informant Interviews**	**Workshop**	**Content Analysis**
evaluation mechanisms important. • Need to build workforce capacity to undertake and implement health promotion interventions to address inequities in health. Linked also to evaluation mechanisms, realistic program design and adequate political commitment to addressing inequities. • Sponsorships important in replacing tobacco advertising with health promoting messages. (Acheson et al., 1998, Arblaster et al., 1996, Emmons, 2000, Gunning-Schepers and Gepkens, 1996, Hogstedt and Lundberg, 2002, Holman et al., 1997, Jennings and Scheerder, 2001, Kawachi and Berkman, 2000, Macintyre and Ellaway, 2000, Mackenbach et al., 2002a, Mackenbach et al., 2002b, Mackenbach and Stronks, 2002, Oldenburg et al., 2000, Prattala et al., 2002, Vilshanskaya O et al., 2003, White, 2004c, White, 2004b, White, 2003, Whitehead,	communities). (ACT Health, 2002)	• Great job of improving those who are already well. *Potentially positive or divergent view* (L) • CFP based on a well recognized international model of health promotion. • Each step of the process is mentored & detailed; supported and supportive. • Appears the focus is right. • CFP provides leverage or seeding funding – need to link grants into other longer term funding sources. • Equity focus of CFP getting better. • Been effective in some areas eg. nicotine patches to people in housing estate, engagement of young people in health promoting ways • CFP provides funding base for organizations to call upon. • CFP gets organizations involved and active in health promotion – more likely to be organizations working with disadvantaged communities.	challenging. • Disempowering: in some instances the target group eg. children don't have control over their environment and can't change risky behaviours. Making them aware of risky behaviours without them being able to act may create anxiety for the children. *Uncertain/unknown* • Multi pronged programs have been shown to be effective but there is still a need for small grants. • How to build on the outcomes of small grants? • Do small grants fail to address the broader issues in the ACT? • Complementarity – are the smaller and larger grants moving in a similar direction? • Should small grants lead to other grants or just have larger grants? • Defining target groups – open to interpretation in some applications eg. what is meant by "family"	

SOURCE OF INFORMATION				
Literature Review	**Policy Documents**	**Key Informant Interviews**	**Workshop**	**Content Analysis**
1995, Wilkinson and Marmot, 2003, Wise and Signal, 2000, Corti et al., 1995)				

GAPS IN INFORMATION: LIMITATIONS

- Limitation with workshop input – organisations (ie. potential applicants) and/or consumers who may be recipients of projects under the CFP participated in the workshop and may have been reticent to discuss any potential negative impacts out of concern that this may result in radical changes to the program and to the loss of a potential source of funding.
- Characteristics of organizations who were funded compared to characteristics of organizations who weren't funded eg. were the larger non-government or peak NGOs funded more than the small, community based NGOs?
- Actual outcomes of the funded projects – there is no mechanism for linking the outcomes/evaluation results from projects back into Healthpact nor information about equity impacts.
- Who isn't applying and what ideas are potentially not being considered for funding.
- Some applicants did not clearly identify either their KFA and/or priority population group(s). In terms of the priority population groups, often had to extrapolate. In addition some of the categories had potential for overlap eg.young Aboriginal and Torres Strait Islander peoples; people who are disadvantaged could also be people of low SES – not clear how these categories are defined and/or how they are understood by applicants. Where specific reference was made to SE status, this was included as a category.
- Also the categories for priority population groups are fairly broad eg. young people – not all young people are disadvantaged or "at risk".

CONTEXT

- Application for funding under the CFP is fairly standard in terms of being application driven and is based on other models of health promotion practice.
- Main objective of the CFP is to build health promotion capacity not to address equity issues per se.
- Health**pact** runs a workshop for new organizations on preparing applications etc as part of the funding round process.
- ACT doing well on behavioural risk factors – according to CHO's report – and focus of action may be better targeting of initiatives in Canberra.
- Strong government commitment to addressing inequalities/gaps – Canberra Social Plan & ACT Health Action Plan. A priority for action in terms of working towards healthy people is a commitment to taking a settings approach to health promotion – neighbourhoods, schools and workplaces.

EQUITY IMPLICATIONS

- Strength based application process: Projects that could address equity issues may not be getting funded because organizations that might do this type of work may not be getting through the application round due to limited capacity to apply.
- Criteria for CFP applicants: organisations that might be interested in addressing equity issues may not be applying for funding because equity per se is not mentioned in key documentation such as the advertisement calling for funding, the application form etc.
- Behavioural risk factors: from a health inequalities perspective the literature suggests that a focus on behavioural risk factors such as smoking cessation or physical activity potentially widen the gap where they focus only on the behavioural risk and not the context in which individuals live and/or assume all individuals have the same capacity to act to change their risk.
- Projects that have young people listed as priority population group have a strong chance of getting funded (66%) – this has potentially positive and potentially negative implications.