



Public social monitoring reports and their effect on a policy programme aimed at addressing the social determinants of health to improve health equity in New Zealand



Frank Pega^{a,b,*}, Nicole B. Valentine^c, Don Matheson^d, Kumanan Rasanathan^e

^a Department of Public Health, University of Otago, PO Box 7343, Wellington, New Zealand

^b Department of Social and Behavioral Sciences, Harvard School of Public Health, 677 Huntington Avenue, Boston, MA 02115, United States

^c Department of Ethics and Social Determinants of Health, Health Systems and Innovation Cluster, World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland

^d Centre for Public Health Research, Massey University – Wellington Campus, Private Box 756, Wellington, New Zealand

^e Health Section, United Nations Children's Fund (UNICEF), 3 UN Plaza, New York, NY 10022, United States

ARTICLE INFO

Article history:

Available online 15 November 2013

Keywords:

New Zealand
Health policy
Social determinants of health
Health equity
Social monitoring
Social reporting

ABSTRACT

The important role that monitoring plays in advancing global health is well established. However, the role of *social* monitoring as a tool for addressing social determinants of health (SDH) and health equity-focused policies remains under-researched. This paper assesses the extent and ways in which New Zealand's (NZ) Social Reports (SRs) supported a SDH- and health equity-oriented policy programme nationally over the 2000–2008 period by documenting the SRs' history and assessing its impact on policies across sectors in government and civil society.

We conducted key-informant interviews with five senior policy-makers and an e-mail survey with 24 government and civil society representatives on SRs' history and policy impact. We identified common themes across these data and classified them accordingly to assess the intensity of the reports' use and their impact on SDH- and health equity-focused policies. Bibliometric analyses of government publications and media items were undertaken to empirically assess SRs' impact on government and civil society.

SRs in NZ arose out of the role played by government as the “benevolent social welfare planner” and an understanding of the necessity of economic and social security for “progress”. The SRs were linked to establishing a government-wide programme aimed at reducing inequalities. They have been used moderately to highly in central and local government and in civil society, both within and outside the health sector, but have neither entered public treasury and economic development departments nor the commercial sector. The SRs have not reached the more universal status of economic indicators. However, they have had some success at raising awareness of, and have stimulated isolated action on, SDH.

The NZ case suggests that national-level social monitoring provides a valuable tool for raising awareness of SDH across government and civil society. A number of strategies could improve social reports' effectiveness in stimulating action on SDH.

© 2013 Elsevier Ltd. All rights reserved.

Introduction

To improve health equity, international organizations, governments and civil society need to develop an understanding of health inequities and implement policies leading to action on social determinants of health (SDH) beyond the health sector (CSDH, 2008). The World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) emphasized the vital role that

monitoring plays in improving health equity with its third overarching recommendation that stressed the need “to measure and understand the problem and to assess the impact of action” (2008, p. 2). Supporting the implementation of the Commission's recommendations, the *Rio Political Declaration on Social Determinants of Health* (WHO, 2011) pledged actions “to monitor progress and increase accountability” (p. 6) as one of five action areas. The *Sixty-Fifth World Health Assembly* (2012) passed a resolution urging Member States “to implement the pledges made in the Rio Political Declaration on Social Determinants of Health” (p. 2), reiterating the importance of monitoring progress.

* Corresponding author. PO Box 7343, Wellington, New Zealand.
E-mail address: frank.peg@otago.ac.nz (F. Pega).

To implement the recommendations of the WHO resolution in all action areas, including monitoring, countries require evidence on policy programmes that tackle SDH and improve health equity (*Can health equity become a reality?*, 2008; *The Sixty-Second World Health Assembly*, 2009; WHO, 2011). The Commission's final report documented the effectiveness of several monitoring tools in supporting a SDH- and health equity-focused policy program (CSDH, 2008). Experience on global and national monitoring of health equity (CSDH, 2008) and the realization of the right to health (Backman et al., 2008; UN, 2006) is increasing. Policy-makers are becoming more interested in monitoring SDH. One aspect of monitoring that has received comparatively little attention in the framework of monitoring SDH is social monitoring.

Social monitoring is “the production and provision of socially relevant information including their presentation” (Habich & Noll, 1994), generally relating to the “economic, political, cultural and socio-psychological aspects of human actors and systems” (Lass & Reusswig, 2002, p. 5). Monitoring SDH, health equity and the realization of the right to health therefore falls within the scope of social monitoring.

Social reporting is a social monitoring tool that aims to provide “information on social structures and processes and on pre-conditions and consequences of social policy, regularly, in time, systematically, and autonomously” (Zapf, 1977, p. 11). Since the introduction of social reporting in the 1960s as part of the social indicator movement (Bauer, 1960), numerous international organizations and governments have produced global and national social reports such as the United Nations (UN) the *Human Development Report* and United Kingdom the *Social Trends* reports (Noll, 1996). Social reporting is generally guided by internationally ratified definitions and measurements of social conditions, processes, determinants and outcomes (UN, 1954, 1989). In recent times, social indicators and broader indicators of development have been harmonized and integrated across international organizations' and states' mandates, such as in the Millennium Development Goals (UN, 2001, 2003). They have also received more prominence in the *Report of the Commission on the Measurement of Economic Performance and Social Progress* (Stiglitz, Sen, & Fitoussi, 2009), which debated the inappropriate use of some national income metrics and the potential for use of different metrics to enhance understanding of quality of life.

Whitehead's (1998) *Action spectrum on inequities in health* theorizes that evidence (e.g., from social reports) translates into comprehensive coordinated policy action via recognition, followed by awareness-raising, will to take action, isolated initiatives and more structured developments, but can also fail to generate action through mental block or denial/indifference. Professional, political and organizational divisions within and between policy institutions are also theorized to hinder translation of evidence into action (Smith & Joyce, 2012). Literature on the impact of social monitoring and reporting on health policy development suggests that social indicators inform health policy development and service planning (Gorman & Labouvie, 2000; Herman-Stahl et al., 2001; Sherman, Gillespie, & Diaz, 1996; Steinmeyer, 2001). The up-take of social report findings is most widespread among organizations involved in producing the reports (Wong et al., 2000). Despite the broader literature affirming the role of social reports, little research exists on their application in the context of SDH- and health equity-focused intersectoral policy programmes.

This paper explores the extent and ways in which the annual *Social Reports* (SRs; Ministry of Social Development [MSD], 2001) supported a policy programme aimed at addressing SDH to improve health equity in New Zealand (NZ) in 2000–2008. The underlying research questions were *To which degree does social monitoring contribute to action on health inequities at the national*

level? and How must such information be presented and disseminated to catalyse action? To address these questions, the paper documents the history of SRs with a particular emphasis on their inclusion within intersectoral health policy initiatives oriented towards SDH and health equity. The policy impact of SRs is assessed by examining both their general use and explicit focus on SDH- and health equity policy programming in government and civil society. Lastly, the lessons learned from the NZ experience are considered in terms of their relevance to similar efforts taking place in other countries.

Methods

Describing SRs' political history

Ethical consent for the study was granted by the World Health Organization (Contract ID: OD/AP-08-01583). We searched scientific databases (Academic Search Complete, MEDLINE, Social Sciences Citation Index) for literature on SRs' political history in December 2012. We were particularly interested in how SRs were initially introduced and what major changes they underwent throughout their development and up until, 2008. Drawing on the literature on SRs' history in relation to SDH and health equity policy development, we wrote a draft description of the SRs' evolution within policy programming in NZ. To validate our description, we conducted five key-informant interviews with senior managers in the NZ Ministry of Health (MoH) and MSD (where SRs are produced). We designed individual questionnaires for each key informant to cover their area of expertise and institutional knowledge about SRs (available from the authors on request). The first questionnaire section focused on the reports' history and relation to health policy. We briefed key-informants about all aspects of the study and interview. All key-informants granted written informed consent to participate in the study. We conducted semi-structured, face-to-face interviews between 45 and 90 min in duration between February and March, 2008. The interviews were audio-taped and transcribed verbatim. Drawing from the information provided in the interviews, we validated and refined our description of SRs' political history. Finally, three experts on SRs and health equity policy reviewed and further validated our description.

Assessing SRs' policy impact

Assessing general use

The first step to assess impact on policy was to examine how intensely SRs have been used across sectors and organizations in government and civil society. This initial examination enabled us to identify sectors and organizations in which SRs were not used, which therefore could be excluded from policy-impact analysis. We collected information on how SRs were used by policy-makers across sectors and organizations in government during the key-informant interviews, as described above, under the second section of the questionnaire.

To inform our assessment of SRs' use among those relevant government departments that we had not gathered sufficient information about in key-informant interviews (treasury and economic development departments and local government) and in civil society, we conducted an email survey with potential SRs users from these groups. We designed and pre-tested a nine-item questionnaire. In our selection of survey participants, we sought potential SRs users at the senior level of their organization. We ensured that our sample of civil society participants was representative across community, health, social and commercial sectors within NZ society. We selected and distributed the email survey to thirty-two eligible participants in May, 2008. Of these, twenty-four

Download English Version:

<https://daneshyari.com/en/article/7336036>

Download Persian Version:

<https://daneshyari.com/article/7336036>

[Daneshyari.com](https://daneshyari.com)