

Guest editorial

What can social care services learn from the equity in health movement?

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There is an emerging movement to promote equity in health, and I think that other human services can learn a great deal from this movement. Seen in a historical perspective, *Diversity in Health and Social Care* is a journal with a cutting edge agenda: promotion of *universal* diversity in human services. Originally, and for a long time thereafter, the research as well as public and professional debate on diversity had been dominated by diversity in terms of ethnicity and culture. First was *categorical diversity* with focus on the cultural elements within groups that were assumed to have a high degree of uniformity. Policy and intervention goals were dominated by assimilation or acculturation, and were associated with pluralistic and melting pot ideologies. This perspective was challenged by *transactional diversity* which focused on boundaries between groups with differential values and behaviour features within groups. Policy and intervention goals were shifted toward solutions that would build on in-group or indigenous ethnic and cultural frameworks. Melting pot ideologies were replaced with resistance to assimilation and acculturation. Although these two perspectives on diversity are different and antagonistic they have one common element: they are both about culture and ethnicity, and exclude or disregard other factors such as age, gender, physical condition/health, and sexual orientation as pertinent to diversity. Several partly concurrent phenomena have generated an alternative perspective on diversity that we may call *managing the diversity*. This perspective goes beyond culture and ethnicity as basis of diversity and recognises multiple grounds for diversity including gender, age, physical condition, biological differences, and sexual orientation. The *managing diversity* perspective has a strong background in the management of workplace diversity, a very common aspect of modern workplaces around the world due to widespread immigration and accelerating globalisation. The proliferation of the managing the diversity perspective from workplace management to client management in human services has been very slow, to say the least. In health services, however, there has been awareness of the

uniqueness of each patient and therefore the need for individualised health interventions (Soydan, 1999).

There is an emerging research and development movement known as *equity in health*, based on similar understanding of human and societal diversity as conceived by the managing the diversity perspective. Equity in health has in turn a strong backdrop in the advance of evidence-based medicine (EBM), the advance of various types of clinical practice guidelines, and the development of the science of systematic research reviews of efficacy and effectiveness studies. Social care researchers and professional practitioners should pay more attention to the equity in health movement to learn about equity and contextual appropriateness in social care practice!

High-quality systematic research reviews are produced by the Cochrane Collaboration (www.cochrane.org) in health and mental health, and by the Campbell Collaboration (www.campbellcollaboration.org) in education, social welfare, and crime and justice. Systematic research reviews of efficacy and effectiveness studies gather, systematise and synthesise high-quality evidence on what works and what is potentially harmful in interventions and policy decisions. The Cochrane and Campbell reviews have revolutionised the quality of clinical practice guidelines as well as other guidelines developed for macro interventions. Typically, systematic research reviews constitute generalised, high-quality knowledge that does not necessarily answer the question of whether the evidence is valid in an unproven context (the problem known in science as external validity). Also, clinical guidelines typically provide recommendations based on generalised evidence.

Evidence-based medicine, and later, evidence-based practice, or EBP in social care, has developed a method of implementing the best available evidence in given organisational and client contexts. Evidence-based medicine addresses the question of how an evidenced intervention would work in individual cases. Generalised and high-quality evidence, drawn from randomised controlled studies and Cochrane and Campbell

reviews, does not respond to this righteous question. Evidence-based medicine tries to do so.

Evidence-based medicine was originally defined by David Sackett and his colleagues (Sackett *et al*, 1997) as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients'. Evidence-based medicine advocates integration of best available evidence with individual clinical expertise and with client values and circumstances. Clinical or professional expertise is reflected in a more effective and efficient diagnosis and in the thoughtful understanding of the individual patient's conditions, values, treatment preferences and acceptability. This aspect of EBM is a recognition of individual patients as unique individuals where diversity may be based on multiple factors such as race, culture, gender, age, physical and mental condition.

For some years equity issues in health have been emerging because of the concerns that public health policy programs hardly reach the poor and disadvantaged groups, despite the fact that there is ample evidence on what works and that huge amounts of domestic and international resources are invested. Notably, through the recent establishment of the Cochrane Health Equity Field (<http://equity.cochrane.org/en/index.html>), a Cochrane Collaboration entity, health equity issues have acquired an institutional base. On its website, the Cochrane Health Equity Field describes its mission:

The Health Equity Field encourages authors of both Campbell and Cochrane reviews to include explicit descriptions of the effect of the interventions not only on the whole population but to describe their effect upon the disadvantaged and/or their ability to reduce socio-economic inequalities in health and to promote their use to the wider community. Ultimately, this will help build the evidence base on such interventions and increase our capacity to act on the health gap between rich and poor.

This field (group) uses the PROGRESS framework referring to groups exposed to inequity by virtue of **place of residence, race, occupation, gender, religion, education, socioeconomic status, and social network and capital**, originally launched by Tim Evans and Hilary Brown (Dans *et al*, 2007; Gwatkin, 2007). The PROGRESS framework is a managing the diversity perspective-based set of tools.

Equity in health has been defined as: 'the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying advantage/disadvantage' (Braveman and Gruskin, 2003). Inequity in health has been defined as: 'differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust' (Whitehead, 1992).

In a recently published article Antonio Miguel Dans and his colleagues (2007) report strategies for improvement of clinical practice guidelines not only in terms of scientific technical aspects (efficacy and effectiveness of health interventions) but also PROGRESS aspects (equity and local appropriateness of health interventions) This work is being developed within the Knowledge Plus Project of the International Clinical Epidemiology Network and proposes a lens for users to evaluate how well clinical practice guidelines address issues of equity. This equity lens is based on five fundamental questions/criteria as follows.

- 1 Do the public health recommendations in the guidelines address a priority problem for disadvantaged populations? For example, in the Philippines under-nutrition is the pre-eminent problem in rural areas, and obesity in the urban areas (Food and Nutrition Institute of Philippines, 2004).
- 2 Is there a reason to anticipate different effects of interventions in disadvantaged and privileged groups? For example, in the USA, hypertension in black people is mediated by processes that result in salt retention, and in whites because of excess adrenergic activity, which pertains to nerve and muscle communication (Lopes, 2002).
- 3 Are the effects of the interventions valued differently by disadvantaged as compared to privileged populations? For example, a study in Thailand found that adolescents' values and perceived decision-making needs were different from those identified by sexual health counsellors (Doull *et al*, 2004).
- 4 Is specific attention given to minimise barriers to implementation in disadvantaged populations? For example, poorer quality of care for diarrhoea among girls in Egypt may be due to the higher value attributed to boys (Yount, 2003).
- 5 Do plans for assessing the impact of the recommendations include disadvantaged populations? For example, in Latin America, fertility rates are higher among those with a low level of maternal education (Castro and Juarez, 1995).

The question is what can researchers and professions in social care do about equity in and appropriateness of social care provision for clients of diverse categories? I think the question is legitimate and appropriate given the fact that huge amounts of resources are invested in social care systems and all client groups deserve fair and just treatment. This ethical and practical issue will remain in focus for some time to come, and social care researchers and professions can learn a great deal from their colleagues in the health arena, or may even collaborate with them.

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