

Inequities in health and the Marmot Symposia: time for a stocktake

Tony Blakely, Don Simmers, Norman Sharpe

Given the prospect of the general election in November, it is timely for a stocktake on what has been done, and what we should do next, to address inequities in health in Aotearoa New Zealand. To heighten the relevance of this stocktake, Sir Michael Marmot is being hosted by the New Zealand Medical Association (NZMA) next week (12 to 14 July 2011) for a series of activities and symposia (convened by the Heart Foundation, and University of Otago, Wellington) to discuss health inequities and ‘what next’.

Marmot has a long pedigree as one of the world’s leading researchers on, and advocates to reduce, health inequities. He chaired the World Health Organisation’s Commission on Social Determinants of Health,¹ led the recent ‘Marmot Review’ of health inequalities in England and Wales,² and has just finished his tenure as the President of the British Medical Association (BMA).

Following the BMA’s direct focus on health inequities, the NZMA is now currently making this a major focus of its activity, and has recently put out its position statement on health inequities.³ The hosting of a visit by Marmot is the next major step in the NZMA’s activity, with the purpose of increasing public and professional awareness of inequities in health and considering what concerted actions should occur next, especially those led by Government.

This paper builds on position papers or ‘fact and action sheets’ that the authors (and other colleagues) have prepared for two symposia during Marmot’s visit, with the purpose of generating discussion and debate. In particular, we focus on what we (i.e. New Zealand as a whole, through the actions of Government, civil society and professional groups) have done to address health inequities in recent decades, and what we should do next. To that end, and to stimulate debate, we have identified a top 10 list under each heading (Text Boxes 1 and 2).

We welcome debate on, and improvements to, our listings—especially ‘what to do next’ (Text Box 2). (Comments can be registered at www.uow.otago.ac.nz/HIRP-info.html.) In addition, as part of the symposia activities, participants will be invited to submit their own ideas on the next 10 most important steps this nation needs to take to reduce the unacceptable and unjust burden of health inequities

Text Box 1. Ten things that have been done that address health inequities in New Zealand in recent decades

Income inequality reduced slightly in the 2000s following large increases in the Gini in the 1980s–1990s. But is perhaps now increasing again.

Social welfare policies have been implemented that in part at least are pro-equity, including *Working for Families* and (soon) *Whanau Ora*.

Intersectoral activities have been implemented that improve health and health equity have been implemented, e.g. retrofitting and insulation of housing stock (energy efficiency and health benefits) and Before School Check and the National Immunisation register.

Many policies relevant to health include equity goals or purposes, including the Health Strategy, Cancer Control Strategy and—more specifically—Reducing Inequalities in Health Strategy, He Korowai Orange and *Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2010–2014*. This has flowed through into programmes, research, health professional training (e.g. cultural competency), and use of health equity impact tools (e.g. HEAT).

Māori health provider, and Māori development more generally, has been a strong feature since at least the 1980s, including the development of Māori health providers and services. The Treaty of Waitangi and Māori health has been enshrined in legislation in the New Zealand Public Health and Disability Act 2000.

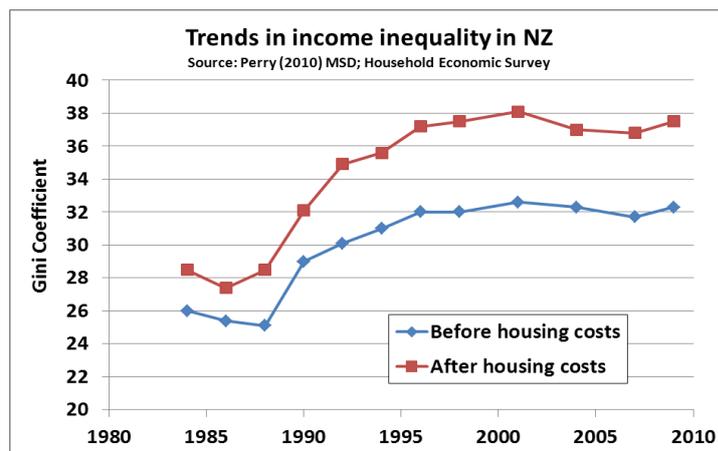
An increasing focus on the needs of Pacific and other peoples has grown in parallel with New Zealand's increasingly multi-ethnic composition, e.g. growing numbers of Pacific providers.

Tailored programmes and health service delivery at the DHB, PHO and other service provider level focusing on Māori, Pacific Island and low socioeconomic people has resulted in increased immunisation rates, improved rates of smoking cessation, cardiovascular risk factor detection and better Type 2 diabetes management.

Funding of health services according to deprivation and ethnicity, as markers of need, is operationalized through various funding formulas.

Research and monitoring on health inequalities, from the development of deprivation indicators to the linkage of census and health data, by Government analysts to academic researchers, has improved our understanding of health inequalities and allowed tracking of progress. However, this activity is currently reducing.

Targets and performance indicators often include metrics by region, ethnicity and deprivation, although Ministry of Health Targets have not been reported by ethnicity or deprivation since 2008–09.



Text Box 2. Ten next most important actions to reduce health inequities in New Zealand

Equitable and fair fiscal and social welfare policy, including progressive taxation, comprehensive and fair social policy, and ensuring that everyone has a minimum income for healthy living. Policy needs to be proportionate to need—what is termed proportionate universalism in the Marmot Review,² or a balance of targeting and universalism.

Maintain and enhance social cohesion, through ensuring all services are accessible by all. This requires a whole of government response and far better coordination among every branch of government, from Ministerial level to service delivery.

Maintaining and enhancing investment in early childhood, including the need to for there to be a visible leadership that champions child health and wellbeing. Child poverty rates need to be reduced. There needs to be greater coordination among services for children, and a visible cross-party agreement that determines the strategy for improving the environment in which children live.

Aligning climate change, sustainability and pro-equity policies, including programmes such as warm and healthy housing in deprived areas to environmental, health and health equity win-wins such as increased walkability of neighbourhoods and financial incentives that both reduce carbon emissions and increase healthy compared to unhealthy food production.

Health equity needs to be widely understood. It affects everyone, whether as a prospective parent, employer, employee, political leader or welfare beneficiary. Everybody working in a service delivery occupation needs to be able to alter their practice to reduce health inequities.

Ill-health prevention that addresses risk factors contributing to health inequities, including making New Zealand Smokefree by 2025 (as per Parliament's response to Māori Select Committee), encouraging or ensuring healthy food formulation (e.g. salt content in breads and cereals, clear labelling of foods that are healthy and unhealthy, packages of taxes and subsidies to improve healthy eating), and stronger policies to tackle harmful alcohol consumption.

Ensuring fair employment and safe and healthy workplaces, extending to include greater access to work for beneficiaries and people with disabilities, a low unemployment rate, and strengthening of occupational health policies.

Maintaining and enhancing Māori, Pacific and Asian policies and programmes, including health promotion, screening and health care services models that are culturally specific or tailored.

Ensuring health services are equitable, including ensuring a strong equity focus in prioritisation of health resource allocation, quality improvement policies and programmes, and improved information systems. This means, among other things, transparent monitoring, smoothing out regional variations in access, and ongoing provider education and support.

Health equity research needs to continue and focus on 'what works', evaluating policies and programmes for equity impacts in processes and (eventually) outcomes such as mental health status and disease incidence.

What has been done to address health inequities in recent decades?

There have been many activities, policies and programmes that address health inequities in recent decades (Text Box 1). Many of these are around processes, such as policies⁴⁻⁷ that flow through to affect health services provision and day to day practice. Importantly, deprivation and ethnicity are now routinely used in funding formulae for DHBs and primary health care. The Māori development kaupapa since the 1970s, flowing through into Māori health providers and influencing mainstream health service practice, has been critical.

Pacific health provider development has also progressed in leaps and bounds. Many—if not just about all—major health promotion programmes and screening programmes include tailored components for Māori and Pacific audiences, for example Māori language components of Quit campaigns. The One Heart Many Lives Programme has been a particular success in heart health promotion focused primarily on Māori men. Specific tailoring of programmes for lower socioeconomic groups, in addition to Māori and Pacific (and Asian), is not as readily identifiable. Nonetheless, by using tools such as the New Zealand Deprivation Index to target more deprived places, activities such as service placement have been altered.

Whilst the recent Government has downplayed an explicit focus on inequities (e.g. initiatives such as “better sooner more convenient” and the push for integrated family health centres), it has been possible to retain likely pro-equity initiatives such as “services to increase access”, PHO funded and coordinated mental health services (such as Wellington’s Compass Health “Primary Solutions”), and the recent push on rheumatic fever prevention.

A big push has been made on research, monitoring and evaluation – although perhaps not as much on programme evaluation as is desirable. A big ticket item on intersectoral activity has been the retrofitting and insulation of New Zealand’s housing stock—especially among lower socioeconomic groups, and a programme that has enjoyed bipartisan support as a win-win addressing both health (including health services demand⁸) and energy efficiency. However, it is challenging to identify other prominent intersectoral activities. Perhaps the concept of Whanau Ora will help in breaking down much of the current siloed thinking around the provision of healthy development and wellbeing.

Times change—and Governments change—as in demonstrated by visiting the Ministry of Health’s website on health targets (www.moh.govt.nz/healthtargets; visited 8 June 2011). Three out of the six targets (immunisation, quitting smoking, and better diabetes and cardiovascular disease services) are clearly relevant to reducing inequities in health. However, the targets are reported by DHB only—not by sociodemographics. You have to search the website archives back to 2008-09 to find targets reported by ethnicity.

Much of the health workforce is acutely aware of the need to address inequities, and likewise the backroom funders and planners, but ceasing routine reporting on trends by sociodemographics leads to invisibility of the issue, and eventual disappearance off policy and practice radars.

So what should we do next?

Progress has been made. The gap between Māori and non-Māori life expectancy has fallen back to 7–8 years—the same level as in the early 1980s, and less than its peak of a nearly 10-year gap in the late 1990s.⁹ But ongoing and concerted policy effort will be required if we are to see both good improvements in non-Māori life expectancy and even faster improvements in Māori (and Pacific) life expectancy so as to close gaps. (For those interested in closing gaps between New Zealand and other OECD countries, the answer is still likely to be the same—maximising reductions in inequities may be the best way to lift the average faster.)

Premature cardiovascular disease mortality has fallen approximately 80% since 1970—but more rapidly in relative terms among non-Māori so that the relative differences between Māori and non-Māori have actually increased during this period.^{9,10} Cancer inequalities are slowly growing, in part a function of tobacco influences on incidence but also generally worse survival among Māori across multiple cancers.^{11–13}

Diabetes, and its incubator obesity, and in turn its progenitor of obesogenic environments, is the growing curse of our times—and if unchecked will be a driver of widening inequalities. Mental health and youth converge as a major issue for New Zealand, as evidenced by our high youth suicide rates—again more so for Māori and lower socioeconomic groups. A recent comprehensive report by the Chief Scientific Advisor to the Prime Minister includes the following observation:

“New Zealand is a temperate, peaceful, ethical and developed nation in which children should flourish, yet it is actually one in which they experience some of the highest rates of adolescent morbidity and mortality in the OECD.” (p.54,¹⁴)

New Zealand is notorious for high child poverty rates and poor social outcomes (including health) among our children and youth—especially among a long tail of disadvantaged children and youth.

What to do? The above report¹⁵ also comprehensively canvasses the range of interventions in early childhood and adolescence to improve outcomes, and notes that many interventions that we currently fund are (based on evidence) likely to be ineffective.¹⁵ For example, single issue education campaigns in schools around drugs. Thus, improved programme evaluation, more skilful scaling up of interventions that appear successful at pilot stage, and redeployment of resources from ineffective to effective programmes, are all ways to increase our “bang for our buck”—and consistent with the ethos of the current political and financial climate.

Moreover, quality early child programmes are often even more effective among lower socioeconomic groups (e.g. family visiting programmes with structured skills development for parents to manage and enhance child behaviour). So, this is a potential win-win; redeployment of existing resources to more effective programmes that also reduce inequities.

Second, and building on the word ‘quality’ that is a priority of the current Government’s agenda (witness the Health Quality and Safety Commission), lifting the quality of health service delivery could be pro-equity. For example, there is some evidence of higher adverse events in healthcare for Māori¹⁶, that may be addressed by quality systems.

Likewise, worse survival from cancer among lower socioeconomic groups and Māori^{11-13,17,18} hint at the likely role of improved access to health care as one way to reduce inequities in health status. As treatments continue to improve in effectiveness, the role of health services will probably increase in importance in the future. And inequalities arising from, or failing to be prevented by, health services are considered by most as being more of an inequity than an inequality (i.e. more unfair), and therefore of higher policy importance to tackle. That all said, the biggest gains in reducing health inequities are still likely to occur outside of the treatment arms of health services.

Tobacco is one— if not ‘the’ example. Making New Zealand tobacco-free is probably the single most important activity to reduce inequalities in health. And such a goal is no longer considered just the pipe dream of academics and radicals. Rather, the New Zealand Parliament (in response to Māori Affairs Select Committee Report) has committed to a goal of making NZ tobacco-free by 2025.^{19 20} We have estimated that achieving this goal, compared to 2006 smoking rates continuing unabated into the future, might result in 5 years gain in life expectancy for Māori, 3 years for non-Māori, and a 2-year reduction in the life expectancy gap – a triple win-win-win.²¹

The future is also going to require joining up the sustainability, climate change and health equity agendas. This will be challenging. Nevertheless, substantial gains on multiple social bottom lines could be achieved simultaneously. For example, improving the walkability of neighbourhoods, reducing our reliance on the automobile, and shifting our agricultural production to a lower saturated fat and lower carbon/methane footing could generate many co-benefits.

The posturing and sabre rattling leading up to the next general election is now well underway. We are being fed a diet of austerity, echoing TINA (“There is no alternative”) of the 1980s. Some reprioritisation is possible, need not lead to widening inequalities, and may even be pro-equity.

For example, and deliberately off the two main Party’s manifestos, by far and away the largest expenditure on welfare benefits in New Zealand is that on superannuation—60% or \$8 billion of the \$13 billion total welfare expenditure budget in 2009.²² Yet the age of entitlement to government superannuation, 65 years, is the same as that in 1899 when life expectancy was 25 years less! And we live in a society with one of the highest child poverty rates in the OECD.²³

As a society we want to celebrate and protect the success of our superannuation scheme, but not to the point of gross inequity compared to younger (and more brown-faced, to be frank) people. Fair go— it is time that the age of entitlement for superannuation is lifted (as it has in other OECD countries), and allow some redistribution to other sections of our society, particularly younger people.

Thus it is indeed timely for a stocktake to address health inequities in Aotearoa New Zealand. We hope this Editorial will achieve the objective of stimulating debate. We encourage the public and health professionals to join in the discussion and debate at this opportune and crucial time about ‘what to do next’ to improve the health of all New Zealander’s, **and** reduce inequities.

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Author information: Tony Blakely¹; Don Simmers²; Norman Sharpe³

1. Health Inequalities Research Programme, University of Otago, Wellington, New Zealand
2. New Zealand Medical Association
3. Heart Foundation

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Correspondence: Tony Blakely, Health Inequalities Research Programme, University of Otago – Wellington, PO Box 7343, Wellington, New Zealand. Fax: +64 (0)4 3895319; email: tony.blakely@otago.ac.nz

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