THE NEW ZEALAND MEDICAL JOURNAL

# Closing the health gap

**Philippa Howden-Chapman,** ***Senior Lecturer;*** **Tony Blakely,** ***HRC Training Fellow, Department of Public Health, Wellington School of Medicine; Wellington:*** **Alison J Blaiklock,** ***Public Health Medicine Specialist, Public Health Promotion, Auckland Healthcare, Auckland;*** **Cindy Kiro,** ***Senior Lecturer, Massey University, Albany, Auckland.***

*"Public health is the art of applying science in the context of politics so as to reduce inequalities in health while ensuring the best health for the greatest number".*[1]

After more than a decade of increasing social and economic inequalities in New Zealand, a Prime Ministerial Committee has been set up to close the 'gaps'. This article emphasises that health status does not just vary across the gap between rich and poor, but is graded across the whole population, and that universal, rather than targeted policies are likely to have more impact on health.

Why do some groups of people consistently enjoy better health and live longer than others? Just as an individual's health is determined in part by the gene pool, the characteristics of the communities in which people live and work – the social equivalents of the gene pool – explain differences in health between groups.[2] The causal pathways are not clearly established, but the link between social organisation and health has been shown in many developed countries. For instance, although many children who live in adverse social and economic circumstances develop into healthy and competent adults, on average, socio-economic disadvantage is embodied in children's height and cognitive development.[3]

Inequalities in the distribution of material resources, income, education, employment and housing, generate health inequalities. All sectors of society are affected: there are no neat 'cut-off' points. As a result, health status is distributed as a gradient up the social hierarchy and applies to almost all causes of death - from cancer, cardiovascular disease and Alzheimer's dementia, to injuries. Individual health-related behaviours such as smoking only partially explain this strong graduated relationship, and such behaviours are themselves socio-economically patterned.

Some economists and conservative politicians maintain that economic inequality is good for incentives, growth and wealth creation. According to this view, equity is a necessary casualty in the pursuit of an efficient economy. The counter argument is that inequality inhibits economic growth by undermining social cohesion, ignoring investment opportunities, lowering levels of education for the poor, reducing spending power and increasing social, economic and political instability.[4] Several cross-national studies have found a negative correlation between the average rates of economic growth and measures of inequality.[5] This appears to happen because countries, like New Zealand, which have large inequalities, invest less in education and other forms of human and social capital compared with countries like Finland and the Netherlands, which have more egalitatian societies.

As Kawachi et al state, "health is one of the most extraordinarily sensitive indicators of the social costs of inequality".[6] Countries that minimise economic inequalities are societies where children and young people are more likely to be able to develop to their full potential. These factors are essential prerequisites for greater prosperity for the country as a whole.

The New Zealand 1996 Census and related surveys show that social and economic inequalities are widespread and have significant effects on health. These health inequalities do not occur just among individuals. People living in more deprived areas are more likely to have poor health and live shorter lives. At a regional level in New Zealand, income inequality (over and above household income) is adversely associated with both mortality and hospitalisation rates .[7]

Woven in with social and economic determinants of health is an additional factor: ethnicity. Maori and Pacific peoples at all educational, occupational and income levels, have poorer health than non-Maori. This suggests there are other, pervasive characteristics of New Zealand society that cause poor Maori and Pacific peoples' health.

The most pronounced indicator of social inequality in New Zealand over the last two decades is the growth in income inequality.[8] Can the negative impact of social inequality on health be reduced by material redistribution? Probably. Governments have the power to redistribute resources through taxes, and in New Zealand, where total tax revenues as a percentage of GDP are below average for OECD countries,[9] there is clear support from the majority of adults for income distribution as a key role of central government.[10] However, increasing the progressivity of income tax will only have an impact on reducing inequality to the degree that wealthy people do not avoid taxes.

Research suggests that redistributive policies probably have an overall positive effect on health and might even benefit those on the highest incomes.[11] But income redistribution is unlikely to be sufficient to eliminate population health differences, when the primary source of inequality lies in the distribution of social and institutional opportunities that affect health.[12] For example, educational and housing investments are critical, as is improving work-place safety.

Herein lies one of the difficulties. The economic incentives inherent in different institutional arrangements may still perpetuate inequalities even as income or occupational gaps close. For example, Maori professionals with tertiary education, in common with other minority groups, still earn significantly less than non-Maori professionals.[13]

Reprinted from The New Zealand Medical Journal, 28 July 2000, Vol 113, No 1114, Pages 301-2

Population-based policies directed to everybody, rather than targeted social and health measures, are (paradoxically) likely to have most benefit for the poor and those with higher risk factors. Policies designed for 'not only the poor' are likely to be more effective and more politically sustainable than policies targeted on class or ethnic categories.[14] The durability of national superannuation is an example. A universal approach may improve overall health status, more especially for the poor, than a targeted approach.

While reducing inequalities is likely to have the greatest impact on population health, health care policy itself remains important. Cross-country comparisons show that if we had universal primary health care services, funded by taxes or social insurance (as do all other countries in the OECD except the USA), access to immunisations and other preventive health care would be greatly improved. The present fragmented system of targeted funding of primary health care services required large out-of-pocket payments for most people, which acts as a deterrent and hinders countinuity of care.

A universal policy approach does not mean homogeneity of services. There are obligations under the Treaty of Waitangi to address the degree to which policies can differentially affect Maori. Mainstream institutions must have strong incentives to ensure Maori have equitable access to resources, including health resources. The approach taken in the 1990s was to provide start-up funds for numerous Maori providers, but it is clear that resources available to many of these providers have been insufficient. Maori providers usually service small groups of Maori, which limits their effectiveness for a population overall with high health needs. The focus on targeted services, often locally-based with limited national links, can create crucial service and information gaps.

Although provision of culturally specific health and education services indicates that the Crown may be responding to its Article II Treaty obligations, attempts to transfer resources to Maori lead to Pakeha cries of separatism. A universal provision of services under Article III would have the advantage of stressing common citizenship. When targeted health services are promoted, care must be taken to ensure they are not isolated and under-resourced.

In conclusion, differences between social, occupational and ethnic groups are the most pressing health problem facing New Zealand. Inequality is unfair and makes us all worse off. But targeting 'the poor' will not minimise the overall social variations in health, may stigmatise poor people and even accentuate health inequalities. Available evidence suggests that a range of mutually reinforcing redistributive policies are needed affecting income, education, employment, housing and health services across the population. This is likely to have a major impact, both to improve New Zealand's health and, over time, increase the country's prosperity.

**Acknowledgements.** We thank Ralph Chapman, Alistair Woodward, Martin Tobias and Colleen Ivory for their comments.

**Correspondence.** Dr Philippa Howden-Chapman, Department of Public Health, Wellington School of Medicine, PO Box 7353, Wellington South. Fax: (04) 389-5319; email: howdenc@wnmeds.ac.nz

1. WHO. Life in the 21st century: A vision for all. The World Health Report. Geneva: WHO; 1998.
2. Evans RG, Barer ML, Marmor TR, editors. Why are some people healthy and others not? New York: Aldine d Gruyer; 1994.
3. Keating DP, Hertzman C, editors. Developmental health and the wealth of nations: social, biological and educational dynamics. New York/London; Guilford Press; 1999.
4. Aghion P, Caroli E, Garcia-Penalosa C. Inequality and economic growth: the perspective of the new growth theories. J Economic Lit 1999; 37: 1615-60.
5. Benabou R. Inequality and growth. NEBR Macroeconomics Ann 1996; 11: 11-74.
6. Kawachi I, Kennedy BP, Wilkinson RG. The society and health population health reader. Volume One. Inequality and health. New York: The New Press; 1999.
7. Howden-Chapman P. (Editor). Social inequalities in health: New Zealand in 1999. Wellington: Ministry of Health; 2000; in press.
8. Statistics New Zealand. New Zealand now. Incomes. Wellington: Statistics New Zealand; 1999.
9. De Kam F, Bronchi C. The income taxes people really pay. OECD Observer 1999; 216: 13.60.
10. Perry P, Webster A. New Zealand politics at the turn of the millenium: attitudes and values about politics and government. Auckland: Alpha Publications; 1999.
11. Ecob R, Davey Smith G. Income and health: what is the nature of the relationship? Soc Sci Med; 1999; 48: 693-705.
12. Sen A. Development as freedom. Oxford: Oxford University Press; 1999; 216: 13-60.
13. Davis P, Howden-Chapman P, McLeod K. The New Zealand Socioeconomic Index: a census-based occupational scale of socioeconomic status. In: Crampton P, Howden-Chapman P. editors. Socioeconomic inequalities and health. Wellington: Institute of Policy Studies; 1997.
14. Goddin RE, Le Grand J. Not only the poor: the middle classes and the welfare state. London: Allen and Unwin; 1987.