

Health Equity & Social Determinants

Overview



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THE MARMOT *Symposium*

(Health Equity and the Social Determinants of Health)

Professor Tony Blakely, University of Otago

Preliminaries

Acknowledgements and conference pack



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Acknowledgements:

- NZMA and University of Otago teams
- Co-funding
 - New Zealand College of Public Health Medicine
 - Public Health Association
 - Prior Centre

Conference Pack:

- Power points of all presentations
- NZMA Equity Statement
- Fact and Action sheets
- Other

- Purposes of today
- Background:
 - Health inequality facts and trends in New Zealand
 - Policy actions in recent decades
- Frameworks and perspectives:
 - What is health inequity?
 - Early childhood and life-course – current examples
 - Universalism ↔ targeting, and ‘progressive universalism’
 - “But can we afford equity?” joining up current agendas
- Where to next for Aotearoa New Zealand?:
 - A possible top-ten list
 - A few specific comments from myself (aka my 7 slides)
 - Risk factors (e.g. smoking)
 - Health services and changing drivers of inequalities

Purposes of today



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1. To sustain and enhance a focus on health inequities.
2. To learn from the English and WHO experience, and assess what might be applicable to New Zealand.
3. To explore visions and objectives for next steps to address health inequalities in New Zealand.

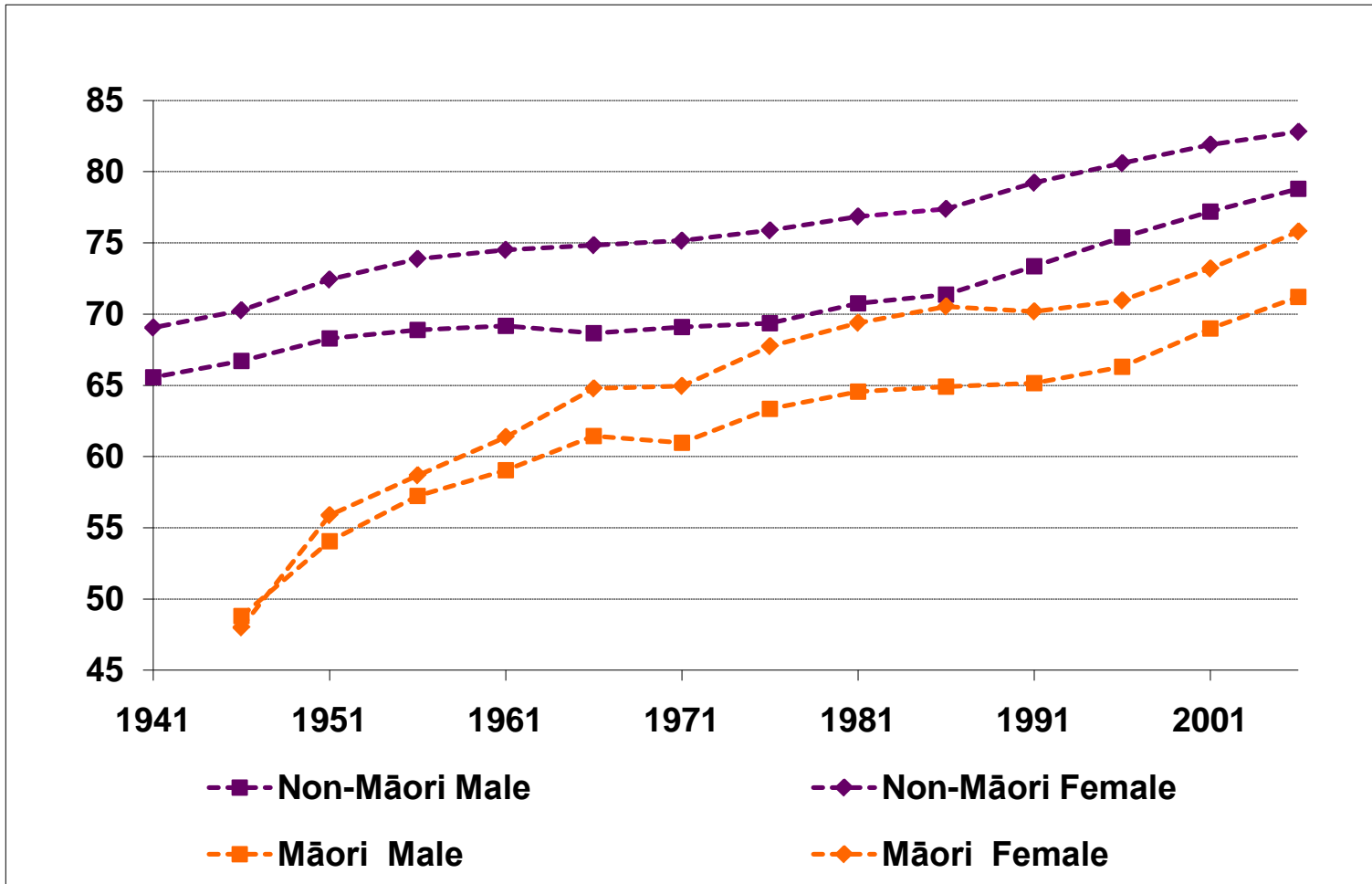
We have included a list of next best 10 actions to take on reducing inequities in health in New Zealand in your conference pack – please consider it, debate it (e.g. during panel session), and improve it (e.g. submit your improvements to www.uow.otago.ac.nz/HIRP-info.html)

Life expectancy trends by ethnicity

The last 60 years

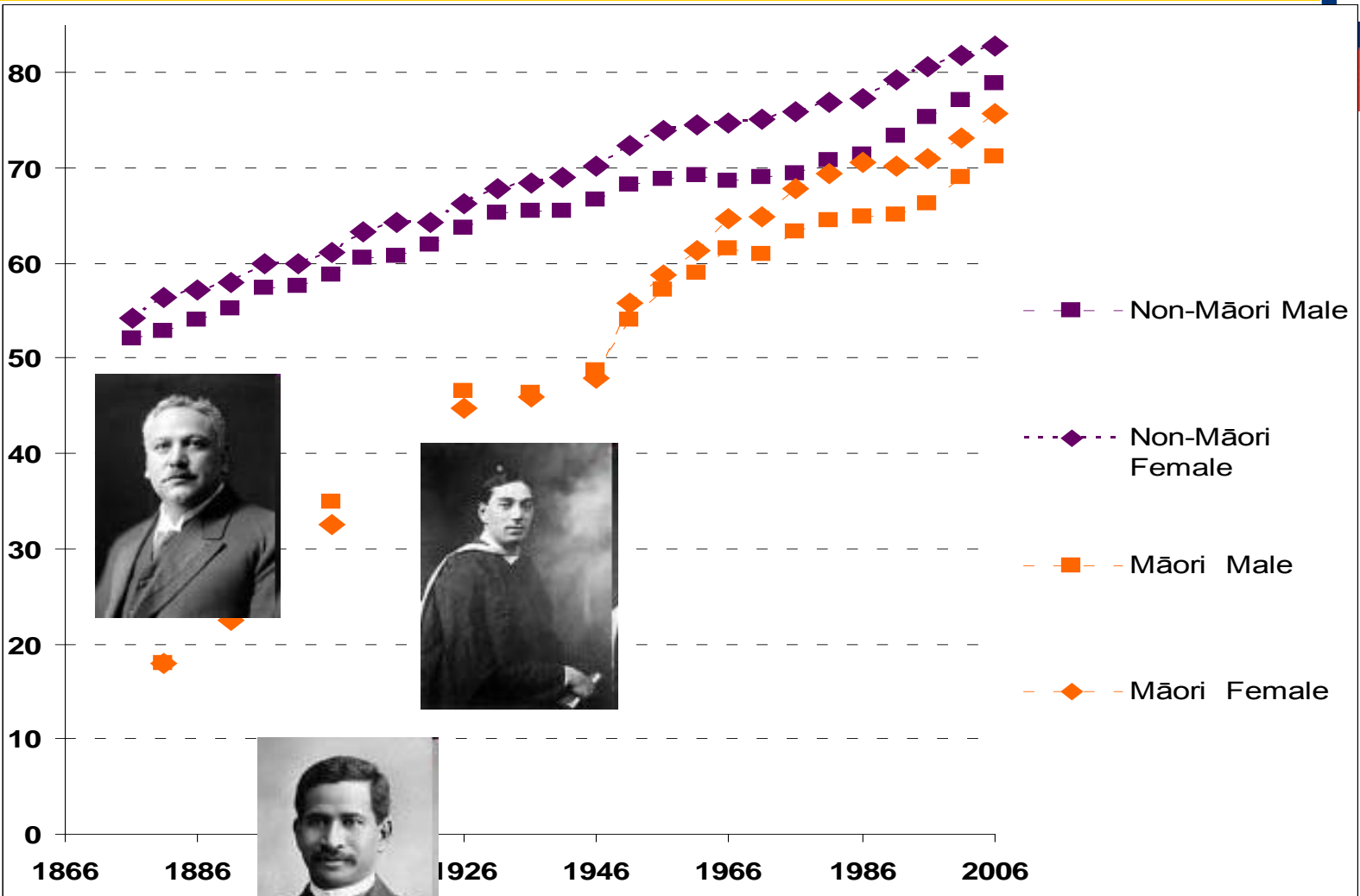


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Life expectancy trends by ethnicity

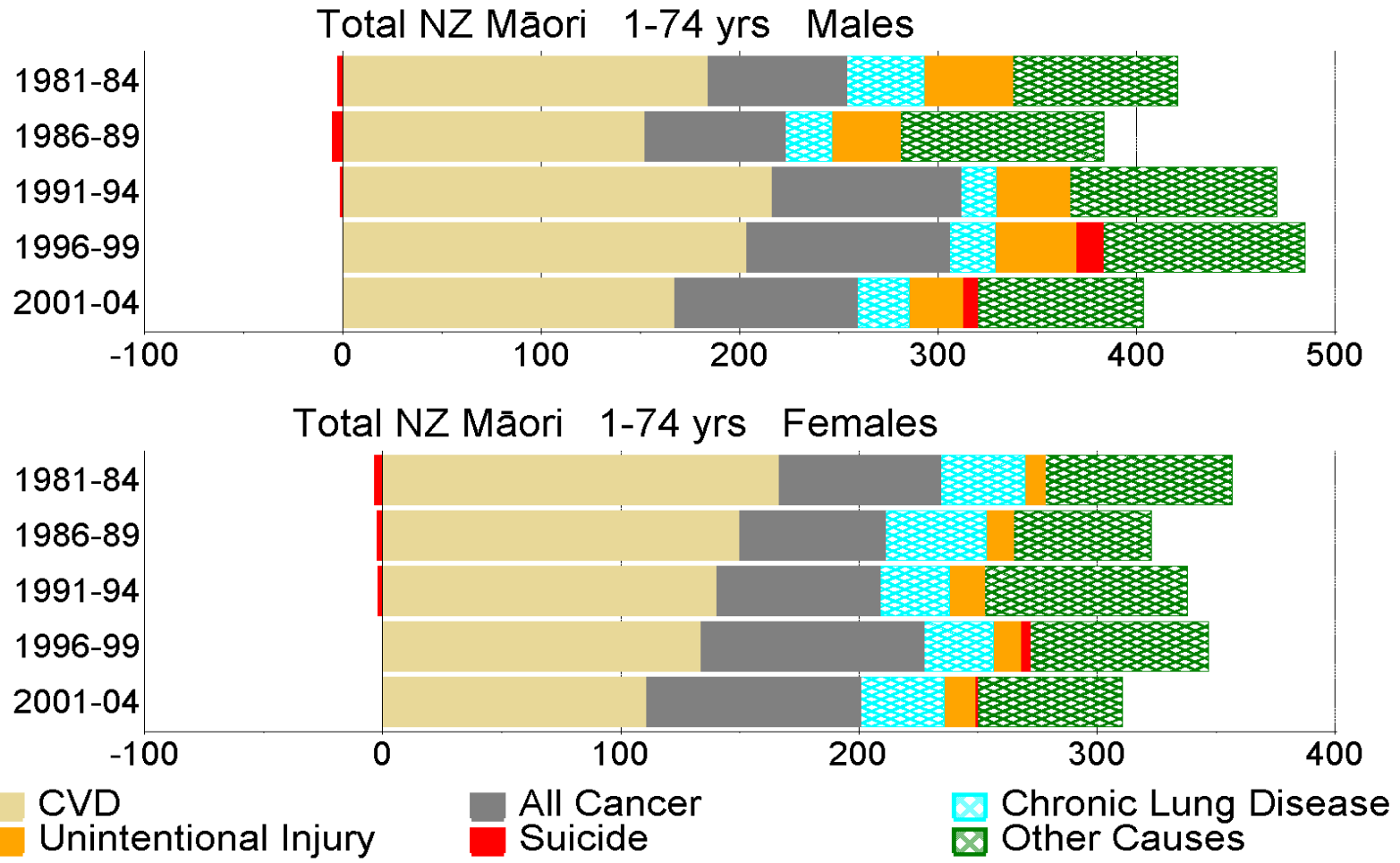
The last 130 years



Source: Woodward and Blakely, History of Life Expectancy in New Zealand, work in progress

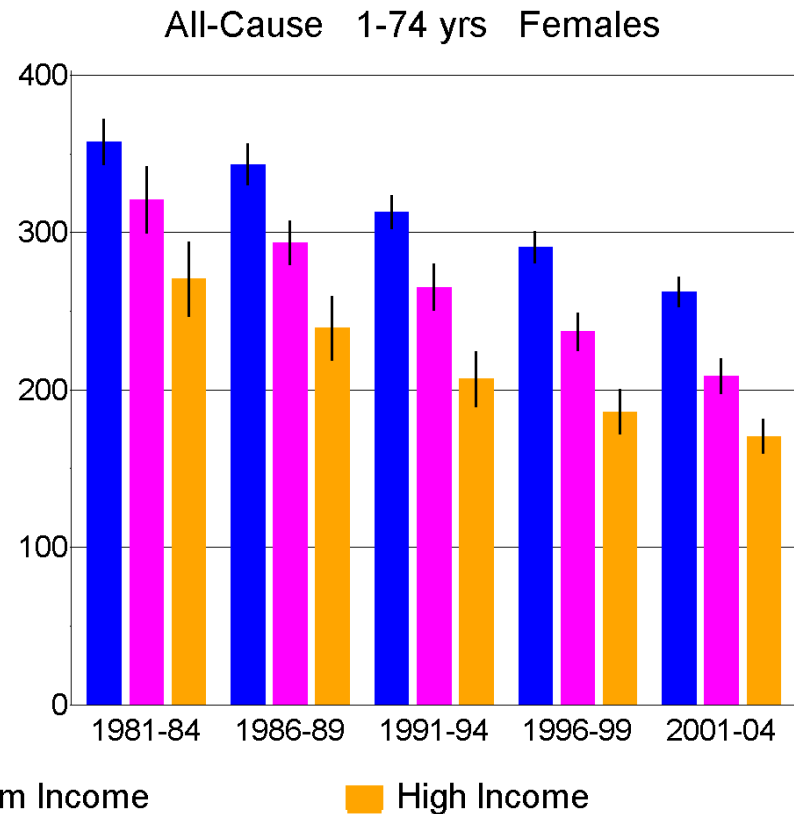
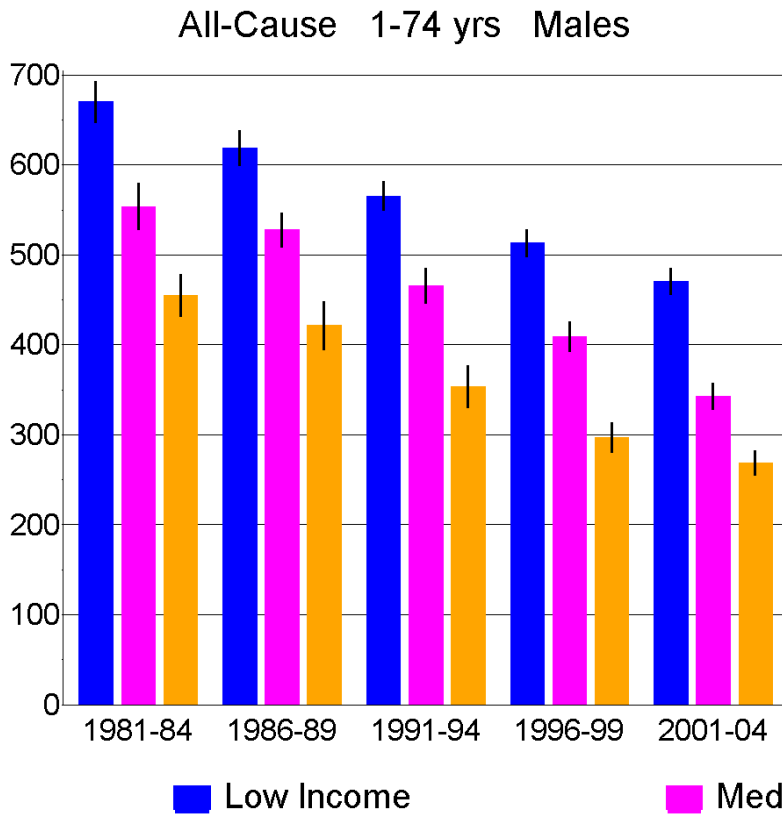
Causes of death driving ethnic ineq

CVD most important, but ↓ over time; cancer ↑



Socioeconomic mortality inequalities

Parallel tracking → constant absolute, but ↑ relative ineq

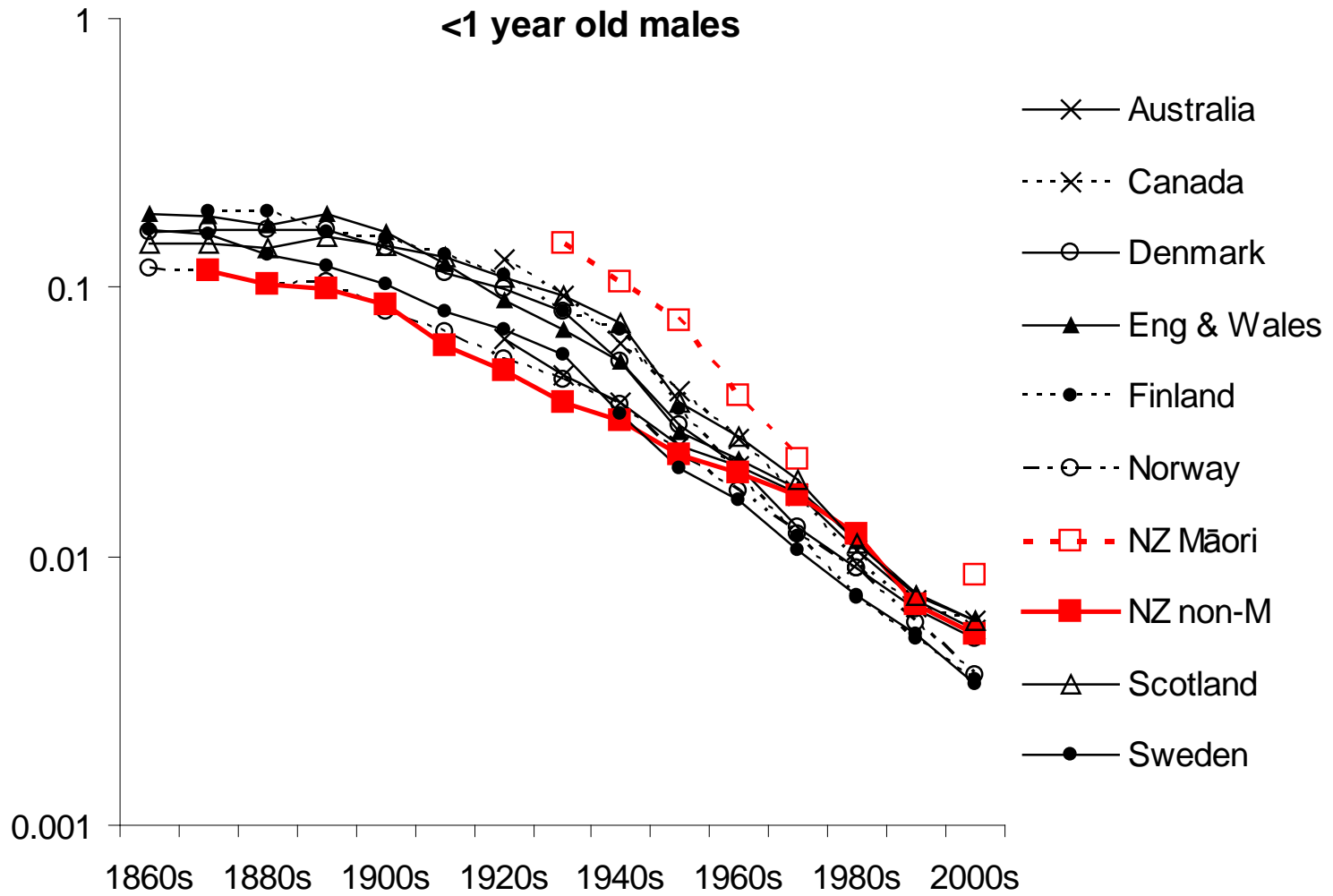


- Mostly parallel tracking in absolute terms
- 30% and 41% decreases for low and high income males, respectively
- 27% and 37% decreases for low and high income females, respectively

NZ used to have lowest child mortality



Similar pattern females, 1-5 yrs, 5-14 yrs, 15-24yrs



Source: Woodward and Blakely, History of Life Expectancy in New Zealand, work in progress. [Primary source; Human Mortality Database.]

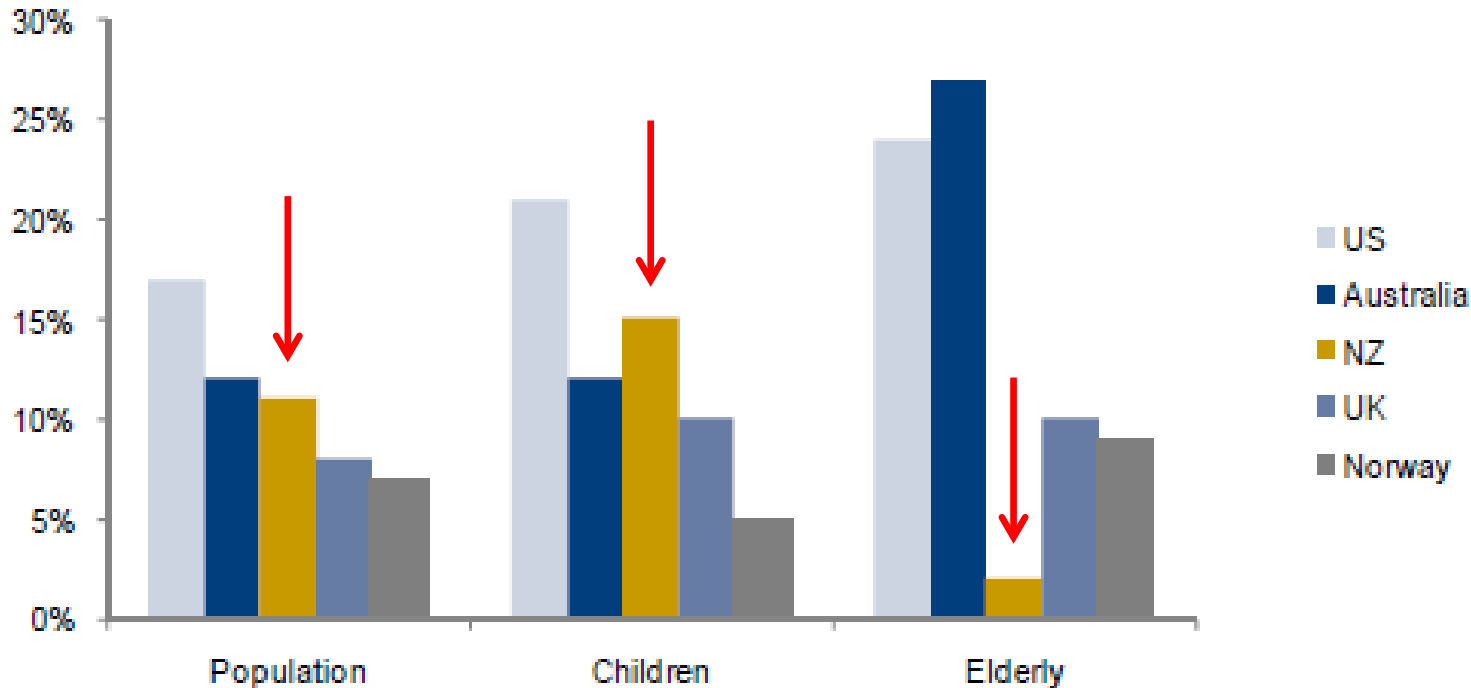
NZ used to have lowest child mortality



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Could our high child poverty rates be part of the reason?

Figure 9 - Proportion living in poverty (below 50% of median income)



Source: MSD (2010) Household incomes in New Zealand. Cited in: Gleisner et al. Working Towards Higher Living Standards for New Zealanders. *New Zealand Treasury*

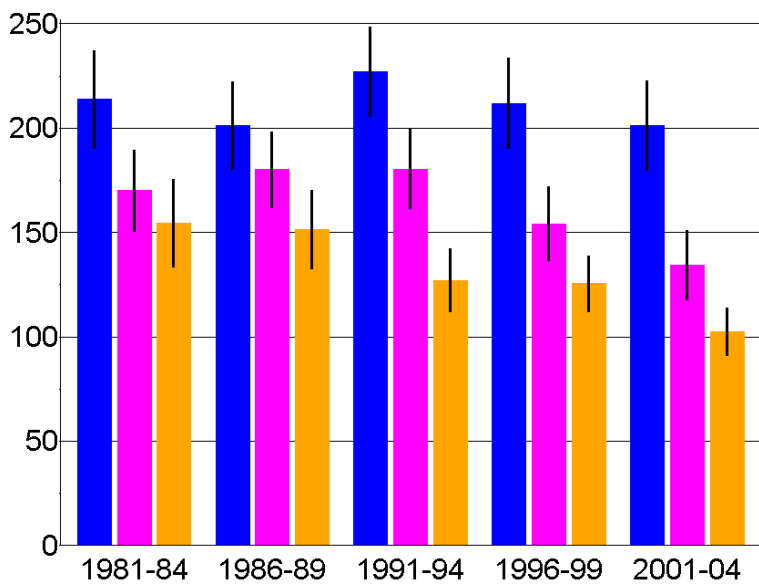
Young mortality inequalities worrying



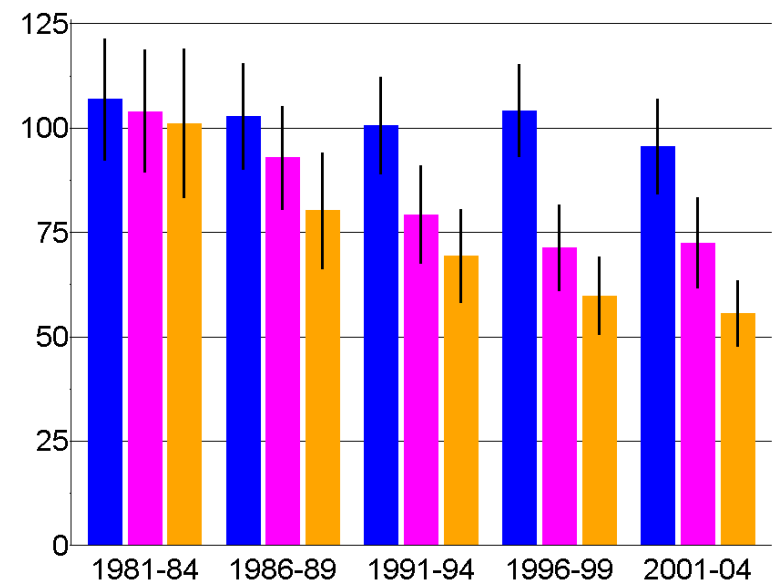
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Little if any improvement in low income, 25-44 yrs

All-Cause 25-44 yrs Males



All-Cause 25-44 yrs Females



What have we/NZ done about it? 1-5



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Quite a bit in recent decades – mostly around process

1. Income inequality reduced slightly in the 2000's
 - but is perhaps now increasing again
2. Social welfare policies have been implemented
 - E.g. Working for Families (at least partially) pro-equity
3. Intersectoral activities implemented
 - E.g. retrofitting and insulation of housing stock (energy efficiency and health benefits)
4. Māori health provider, and Māori development more generally, has been strong:
 - E.g. ToW and Māori health in Public Health & Disability Act.
5. Increasing focus on the specific needs of Pacific

What have we/NZ done about it? 6-10



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Quite a bit in recent decades – mostly around process

6. Many policies include equity
 - has flowed through into programmes, research, health professional training (e.g. cultural competency), and use of health equity impact tools (e.g. HEAT).
7. Funding of health services by deprivation & ethnicity
8. Tailored health promotion and service delivery
 - E.g. Māori language messages in tobacco control
9. Research and monitoring on health inequalities
 - has improved our understanding and allowed tracking
10. Targets and performance indicators routinely include metrics by ethnicity and deprivation.

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 - **Early childhood and life-course**
 - **Universalism ↔ targeting, and ‘progressive universalism’**
 - **“But can we afford equity?” joining up current agendas**
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What is an inequity in health?



Guiding principles, but still tricky to decide

Whitehead's 7 determinants of health inequalities/differences:

1. Natural, biological variation.
2. Health-damaging behaviour if freely chosen (e.g. risky sports).
3. Transient health advantage of one group over another, due to one group adopting healthier practises earlier.
4. Health damaging behaviour where the choice of lifestyles is severely limited.
5. Exposure to unhealthy, stressful living and working conditions.
6. Inadequate access to essential health and other public services.
7. Natural selection of health-related social mobility, involving the tendency for sick people to move down the social scale.

Early childhood and lifecourse



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Research boom → basis for evidence-based policy

- Two recent reports:
 - PM's Chief Science Advisor
 - ECE Taskforce
- Highlight relevant issues for today:
 - Evidence on interventions
 - Efficiency
 - Universalism vs targeting
 - Pro-equity vs inequity increasing programmes
 - Quality

Improving the Transition

Reducing Social and Psychological Morbidity During Adolescence

**A report from the Prime Minister's
Chief Science Advisor**

May 2011



An Agenda for Amazing Children

Can we afford reducing health inequity?



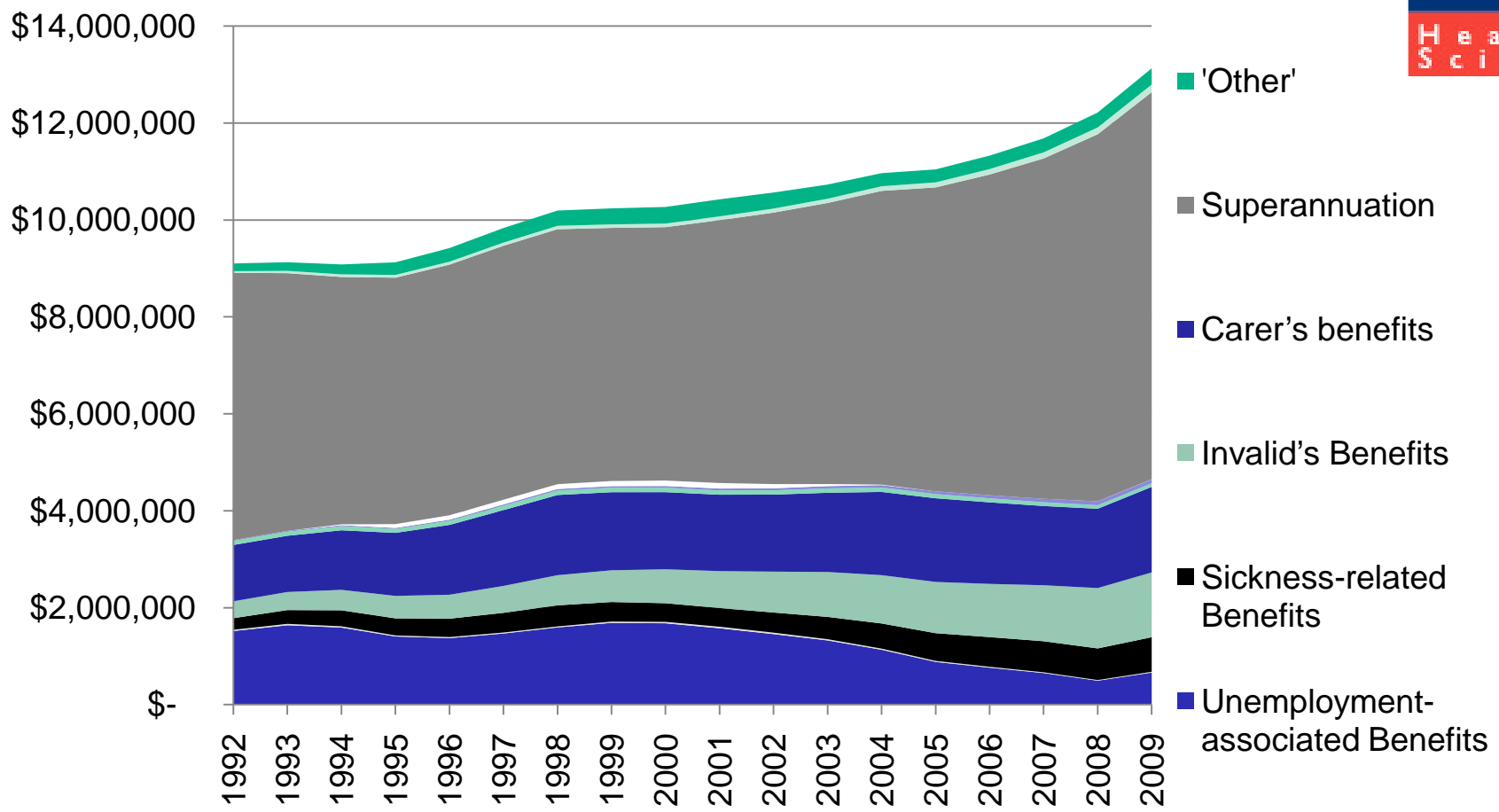
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Yes – social investment with major paybacks

- Cost effectiveness:
 - Generally agreed that better quality early childhood interventions return up to \$10 to \$20 per \$1 invested
 - Public health prevention programmes – especially population-wide ones such as alcohol tax, salt reformulation in foods – cost saving and likely pro-equity (Vos et al, ACE-Prevention, 2010)
- Redistribution of societal investment is possible:
 - For example, consider welfare benefits

Benefit expenditure over time

By far and away the biggest 'benefit' is superannuation

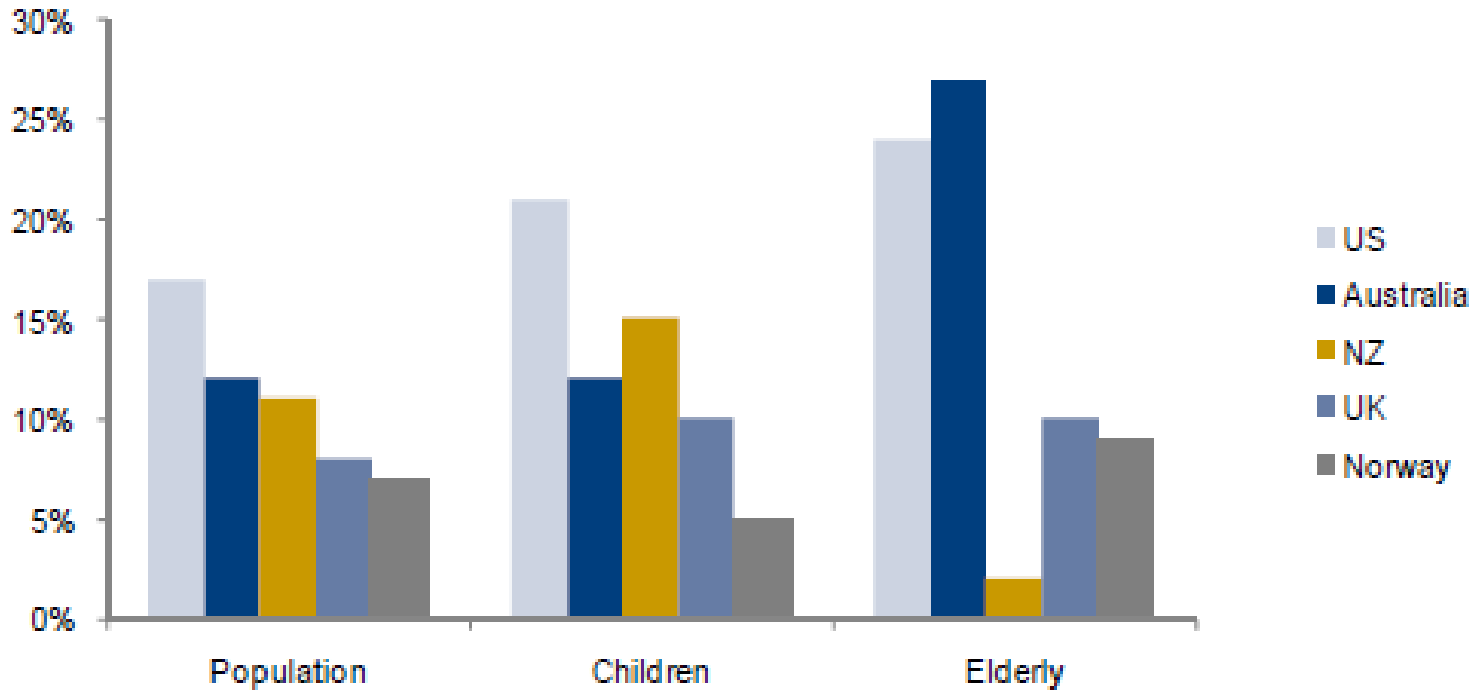


Source: MSD (2010) The Statistical Report

[Note: excludes Working for Families, which in 2008 was about: \$2.6 million tax credits; \$0.85 million accommodation supplements; \$0.15 childcare assistance.]

Yet we tolerate high child poverty

Figure 9 - Proportion living in poverty (below 50% of median income)



Increasing age of super entitlement



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Seems only fair, and will free up resources

- Age of entitlement set at 65 yrs in 1899. Since then life expectancy has increased by about 25 years!
- Other OECD countries increasing age of entitlement. We should too, so long as living standards of people who cannot work >65 yr are protected
 - E.g. by having Invalid's benefit – and indeed all Benefits including Superannuation – set at an income necessary for healthy living (a.k.a. “Minimum Income for Healthy Living” as recommended in Marmot Review)
- Such redistribution within Welfare would allow shifting of resources to address child poverty.

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What to do next?



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Lets debate, improve and then try to act on this list

1. Equitable and fair fiscal and social welfare policy
2. Maintain and enhance social cohesion
3. Maintaining and enhancing investment in early childhood.
4. Aligning climate change, sustainability and pro-equity policies
5. Health equity needs to be widely understood
6. Ill-health prevention that addresses risk factors
7. Ensuring fair employment and safe and healthy workplaces
8. Maintaining and enhancing Māori, Pacific and Asian policies and programmes
9. Ensuring health services are equitable
10. Health equity research to continue and focus on 'what works'.

Blakely T, Simmers D, Sharpe N. Inequities in health and the Marmot Symposia: time for a stocktake.

NZ Med J, 8 July 2011

Fact and Action Sheets – in your conference pack

Health care matters



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Treatments improve + costs escalate = inequities likely

- Consider that:
 - Half of the huge reductions in CVD mortality in last 30 years due to improved treatments
 - Cancer mortality gaps slowly opening up, and survival worse for Māori (and to some extent lower socio-economic groups)
- Which makes an equity focus important in:
 - prioritisation of health resources (new National Health Committee)
 - quality of services (Health Quality and Safety Commission)
 - information systems:
 - recall systems that stop people falling between the gaps
 - for monitoring and research

Estimating LE by ethnicity in 2040

Tobacco ~~control~~ eradication matters



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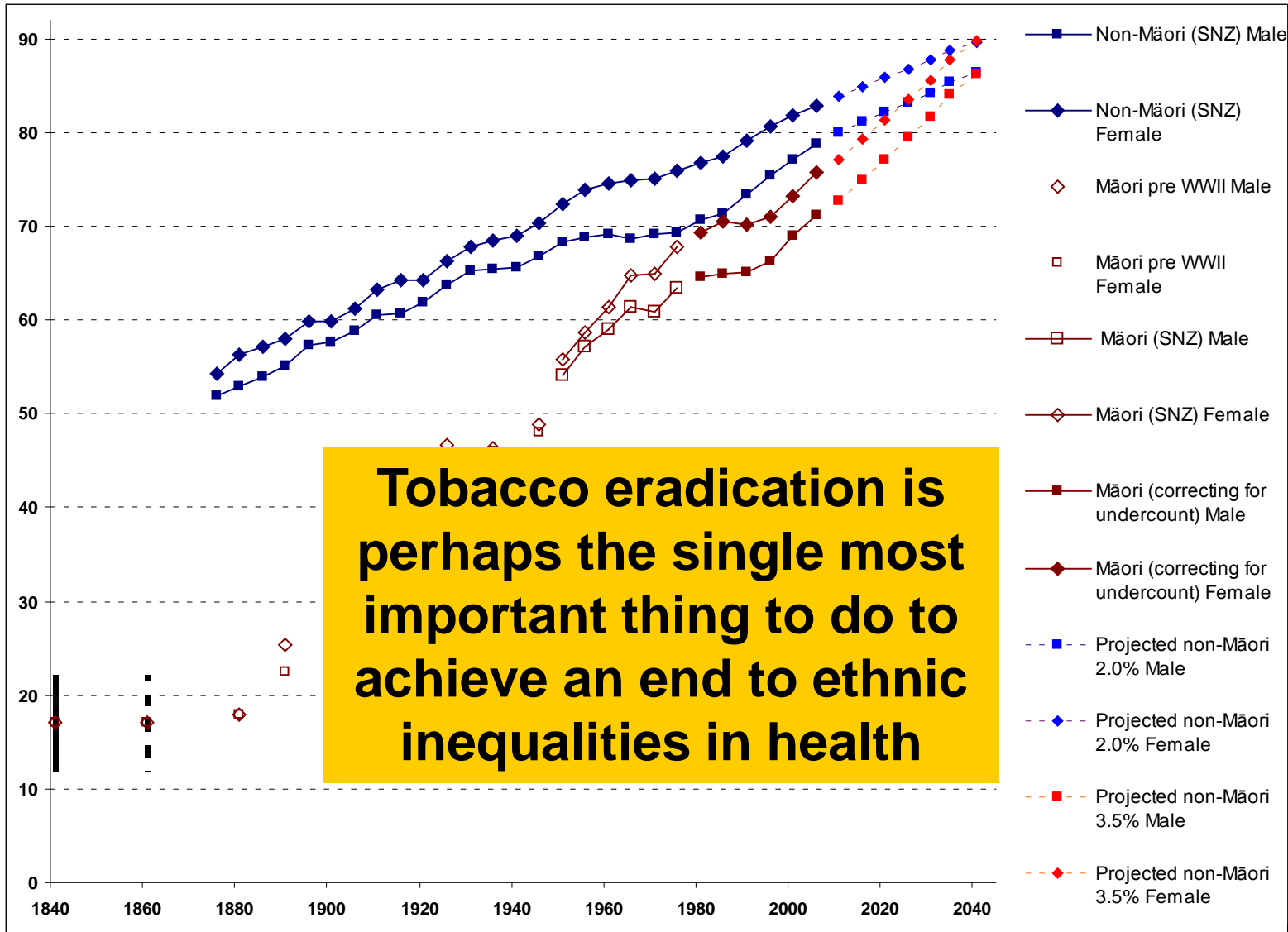
- If we go smokefree (compared to 2006 smoking rates continuing unchanged into the future), we estimate that by 2040:
 - an additional 5 year gain in life expectancy for Māori
 - an additional 3 year gain for non-Māori
 - and therefore a 2 year closing in ethnic inequalities in life expectancy
- Making New Zealand smoke-free is achievable, and worthwhile

20/20 vision on 2040

Visioning the end of Māori-nonMāori inequalities in LE



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Back up slides



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Infectious diseases

A resurgent source of inequalities

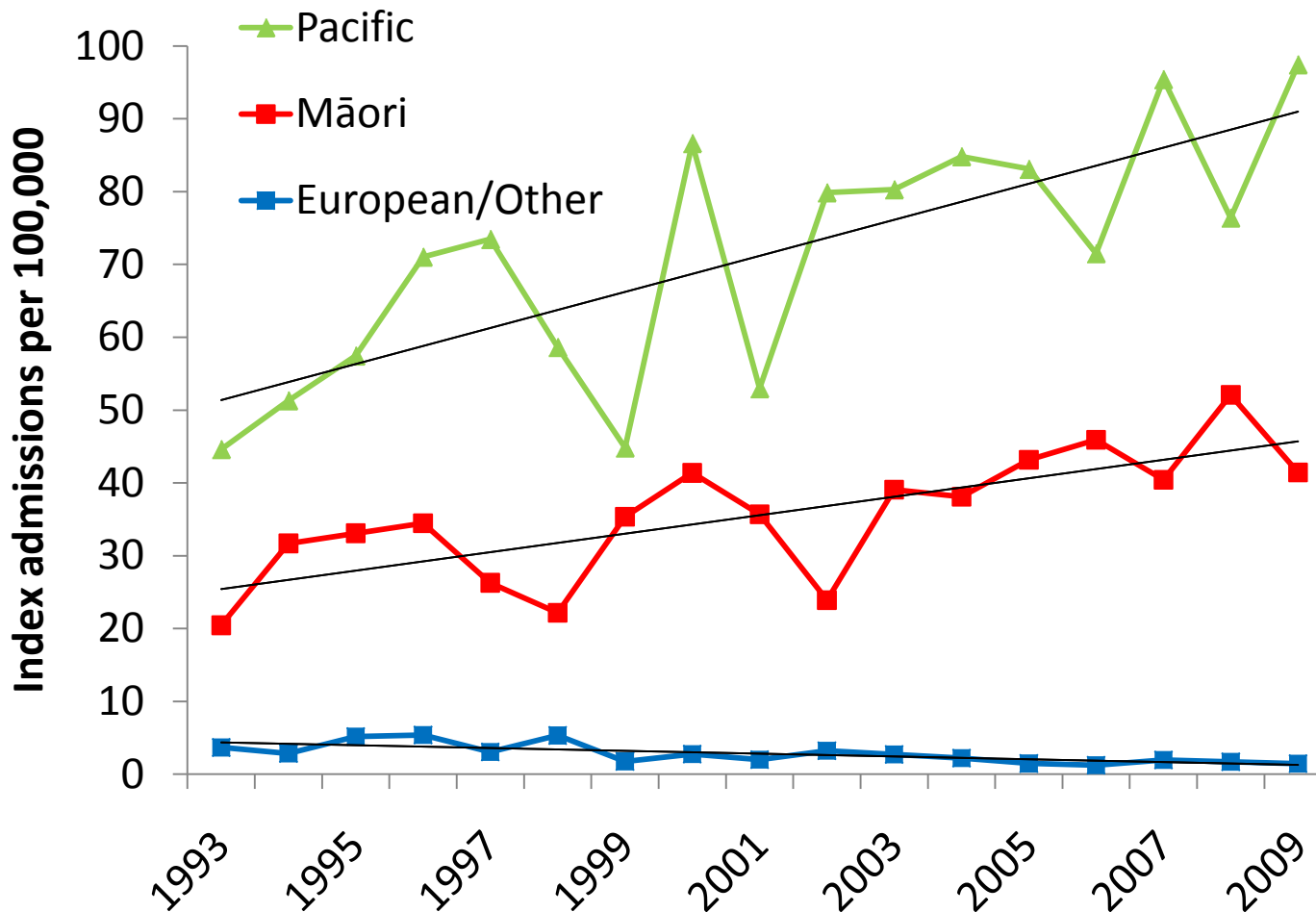


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- Rheumatic fever very high by international standards among Pacific and Māori – approximately 40 and 20 times the European/Other rates respectively.
- Rheumatic fever is associated with crowding and poverty, and is usually rare in rich countries these days.
- Close contact communicable disease hospitalisation rates not falling over time, and much higher for Māori and Pacific (Baker et al, in progress)

Rheumatic fever rates

Perhaps the most prominent health inequality at moment

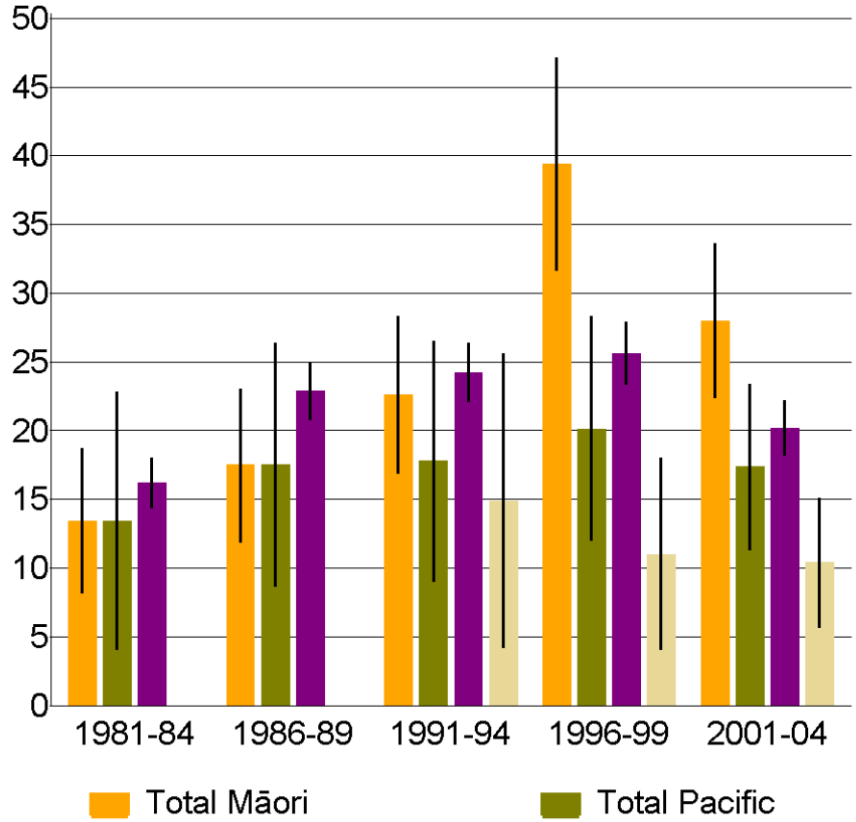




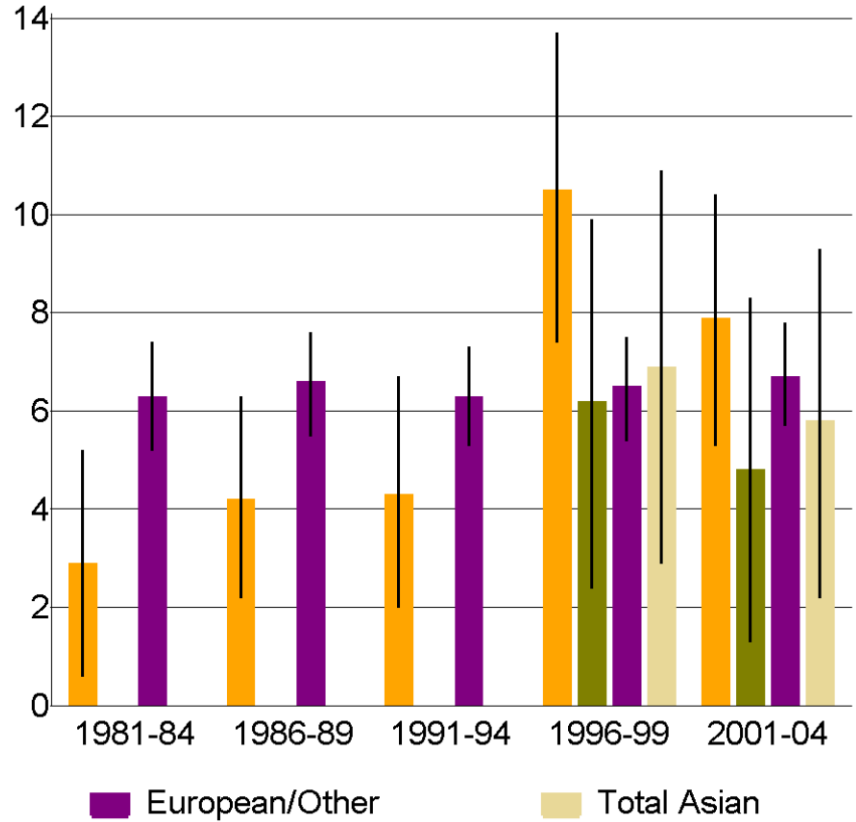
Suicide rates by ethnicity

High youth and Māori rates

Suicide 1-74 yrs Males



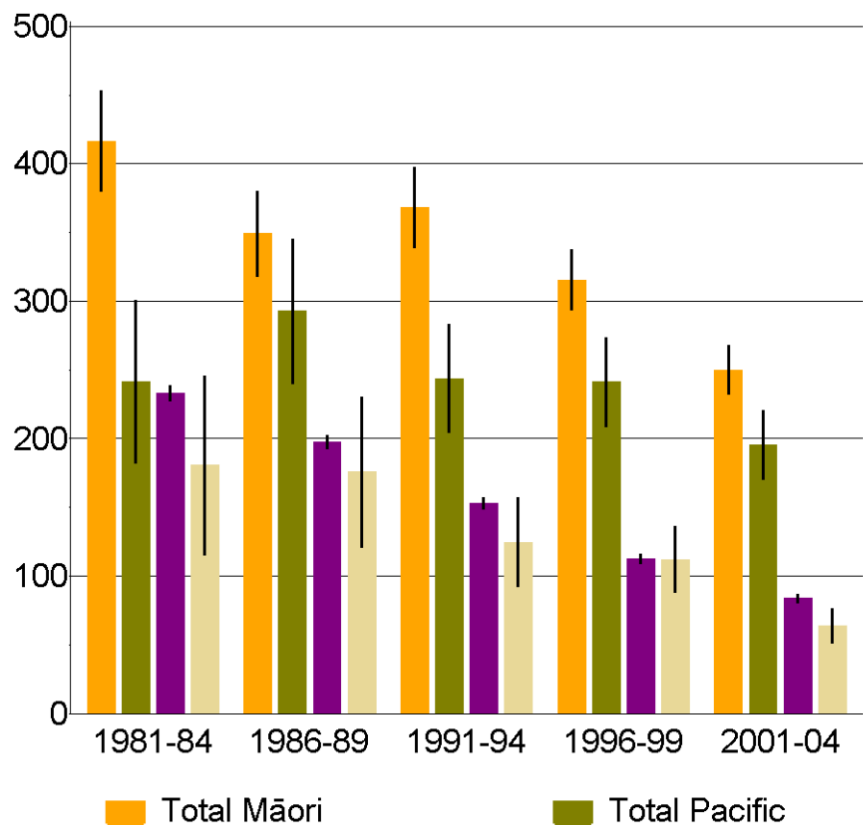
Suicide 1-74 yrs Females



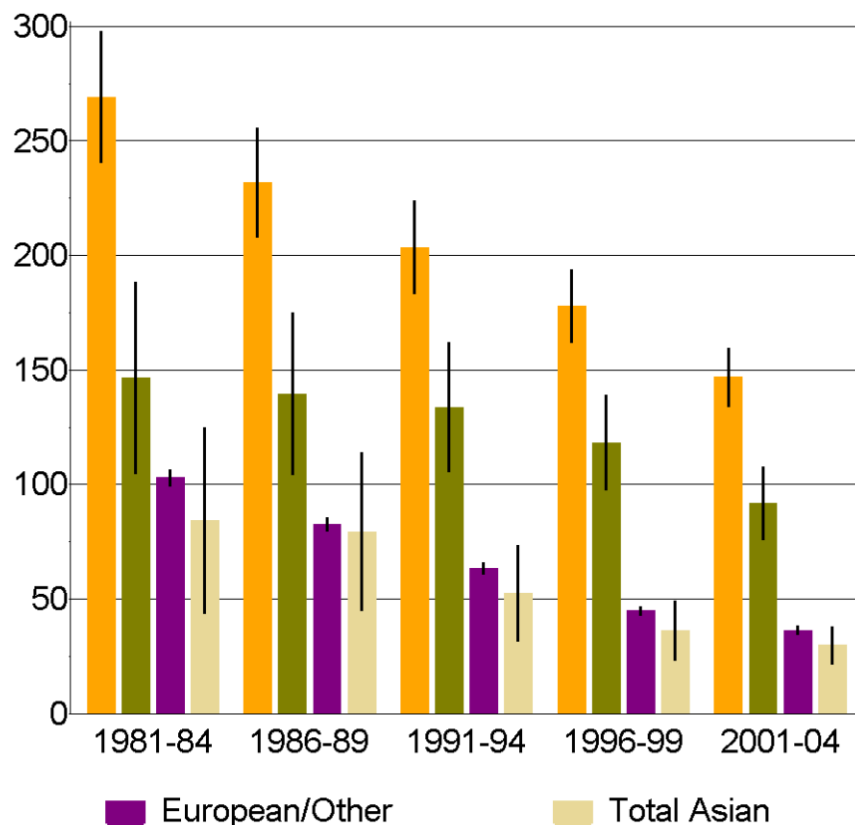
CVD mortality rates by ethnicity



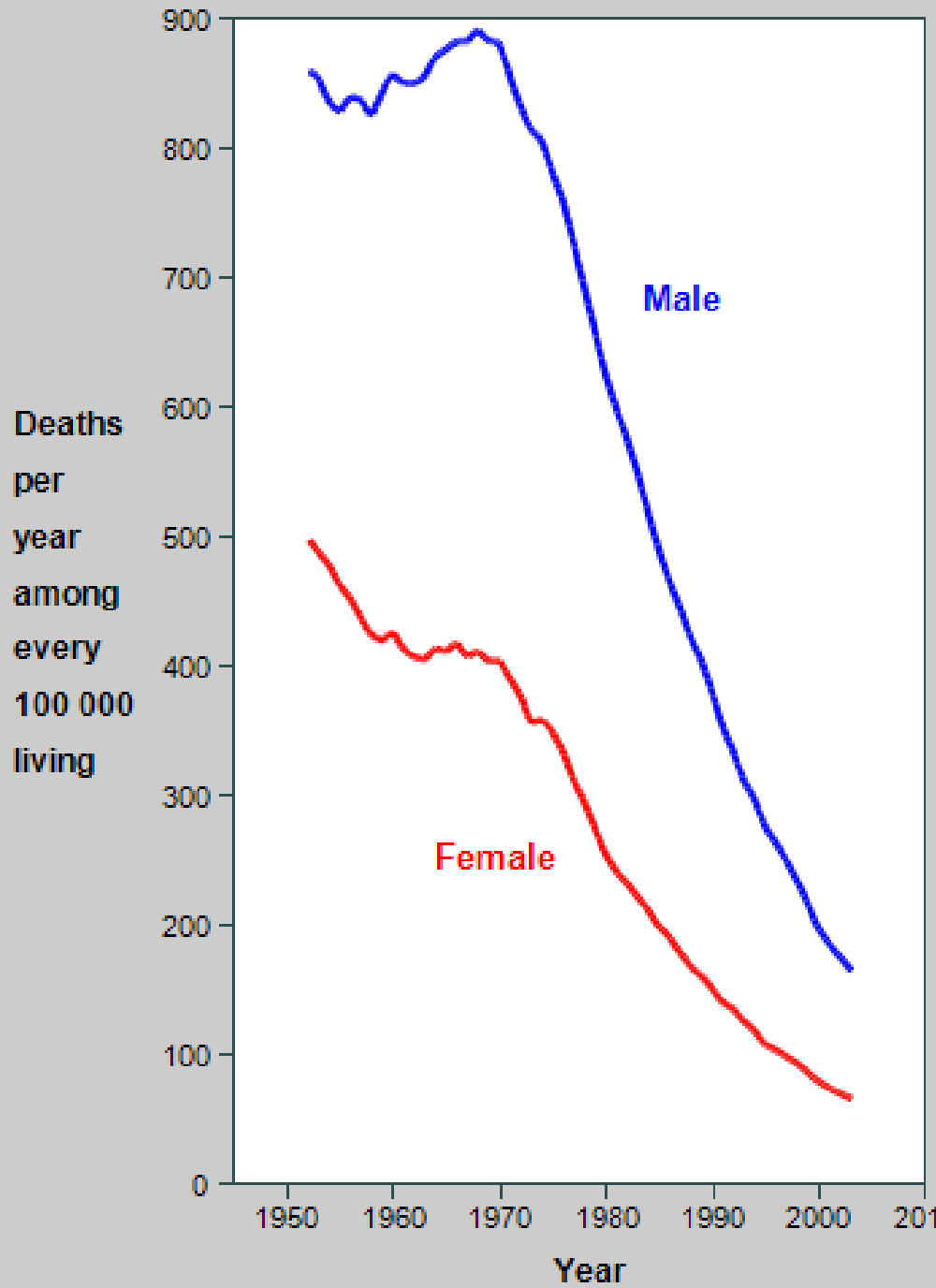
CVD 1-74 yrs Males



CVD 1-74 yrs Females



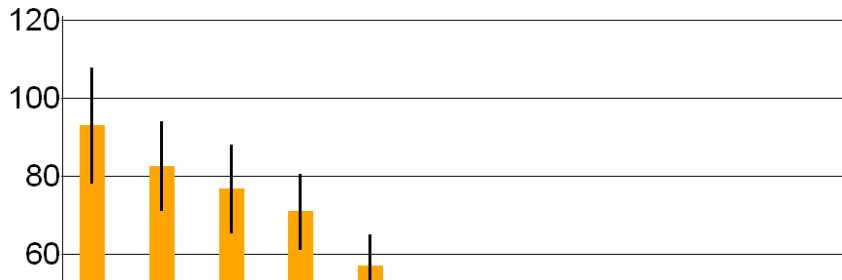
35-69 yrs, CVD
mortality, Australia
www.mortrends.org



Suicide and injury death rates by ethnicity



Injury 1-74 yrs



Suicide 1-74 yrs

