

## **A Symposium on Health Equity and the Social Determinants of Health**

**Address by Chair of NZMA Health Equities sub-committee Dr Don Simmers**

**Wednesday 13 July 2011, Wellington Medical School**

Nau mai, haere mai. On behalf of the New Zealand Medical Association, I warmly welcome you to this significant and much-anticipated event.

It is testament to the pulling power of Sir Michael Marmot that attendance at this symposium has not only been booked out for weeks, but it has attracted a long waiting list as well.

Twelve months ago the NZMA made the decision to develop a Position Statement on Health Equity. The idea to act on this issue was in fact inspired by Sir Michael. Early in 2010 he was about to take up the role of president of the British Medical Association. He had also just completed his chairmanship of a Strategic Review of Health Inequalities in England and its report *Fair Society, Healthy Lives* had just been published. The juxtaposition of these events provided a perfect opportunity for the NZMA to act, and with the encouragement of Professor Tony Blakely a health equity subcommittee was established and activity began.

But Sir Michael had also provided inspiration on a much more personal level. In 2002 my wife, Annabelle, and I moved from Queenstown to Wellington. This midlife move, often questioned by incredulous Wellingtonians, was more about life outside of medicine, but after sampling a number practices around the city I decided to meet the challenge of working in a more disadvantaged area – right here in Newtown.

It didn't take too long before I became aware of a contrast between my patients in the Queenstown area and the patients I was beginning to meet in Newtown. I was struck by the high number of people who were affected by a whole range of diseases including the more predictable obesity, diabetes, and heart disease but also asthma, thyroid disease, rheumatoid arthritis, gout, developmental delay, skin infections, drug addictions and congenital disease. I encountered far more anxiety and depression here in Newtown, along with the effects of violence whether domestic, the result of criminal activity, or that suffered on Courtney Place. For the first time I started to encounter post traumatic stress disorder, and the life-long profound effect domestic violence has on those who experience this as children. By contrast, I recall a psychiatrist who came from Invercargill to do clinics in Queenstown would often remark that, although there was a predictable incidence of schizophrenia and bipolar disorder, there was a distinct lack of depression.

In Newtown many people begin to age even as early as in their 30s. Compared with what I was used to, they looked and behaved as though they were a decade or two older than their chronological age. I now have patients as young as in their late teens with Type 2 diabetes, and gout occurs in 20 year olds – but these examples are the mere tip of an iceberg where changes are often more subtle. People seem tired and worn out whether through the grinding drudgery of their mundane work, or trying and failing to

make ends meet on benefits. There is a despair that unless they go for all they can get out of the system, they'll miss out. They have nothing to fall back on.

In the late 90s a senior lawyer in one of Queenstown's law firms was quoted in a local newspaper as saying "there is no poverty in the Queenstown area", and immediately qualified this by saying "certainly there are people struggling financially, but they always have the option of leaving and being better off in another town". Even though young families had to work incredibly hard just to make ends meet, and this included both parents often working seven days a week during holiday periods, they still retained a sense of dignity and purpose in what they were achieving, by merely existing in the Queenstown area. In Newtown by contrast these qualities are not nearly so prevalent. Having the perception of living on or at least near to the bottom rung does this to people.

All of what I'm saying is of course a generalisation, and has not one jot of scientific data to back it up. I guess it would be easy enough to research this contrast, but really with all the data already available both internationally and here in New Zealand, that has already quantified this difference between people who live in well off areas and those who live in poorer suburbs. I don't think quantifying the difference in health status between the Wakatipu Basin and Newtown is going to be of earth shattering significance. To me personally however, the contrast is enormous. I do want to add, these differences may be as much about perception as actual physical differences. In many instances the quality of life achievable may be not that much different.

About six years ago, quite by chance, I happened to read an article by Richard Sapolsky, a rather peripatetic North American scientist, who at that stage was into the relationship between the social gradient as it applied to baboons and their corresponding cortisone levels. He made reference to Sir Michael Marmot's UK Civil Servant Research as the "Rosetta Stone" of social determinants research where he had proven that occupational status played a significant role in the incidence of many diseases as well as mortality.

Since then it has been the work of Sir Michael and many others that has provided many of the answers to what I was seeing in my practice, and was not just about the differences being due to the way two different populations select themselves.

What this research shows is that for each and every one of us our life's trajectory, in terms of health, wellbeing and longevity is not set in stone at the moment of conception – far from it – indeed by far the most important factors that determines this trajectory is the social and physical environment within which we live, and that if we move from one environment to another – even as adults – our health status will change. Therefore, if through no fault of our own we get exposed to an environment, whether in utero, or during infancy, childhood, as a teenager or as an adult, that has a deleterious effect on our health and longevity then we have an issue of equity. In other words, it's not fair that this should happen.

But as well as considering these factors that may affect our health from a personal perspective, we should also look at how this issue affects us indirectly. If we were to address health inequities effectively:

- the quality of life around us would improve
- through more people enjoying more disease free years in their lives, precious health dollars can be diverted to other priorities
- there would be a decrease in violence
- there would be fewer people crippled by mental illness
- the cost of incarceration would decrease
- more people would reach their productive potential
- fewer people would be unable or unwilling to work, whether through mental illness or disease.

If the cost of health inequities was to be calculated for New Zealand it is likely to be in the order of 10s of billions of dollars. We should not be put off doing anything because of a fiscally restrained environment.

So, to recap we know a lot about the relationship between our physical and social environment and how this determines, more than anything else what our health status will be, but what we're not so sure about is what *actions* we as a civil society can take to address the issue.

Of course, some actions have already been taken but we are a long way short of seeing whole of government, whole of society coordinated activity to really make the easily measurable quantum leap required.

Nevertheless, progress has been made and we have attempted to list the top 10 effective changes that have already occurred here in New Zealand. This has been enclosed with the pack you received today. As well as actually identifying what has worked, we need to tease out *why* it worked.

We need to also need to take note of the failures – both here in New Zealand and internationally.

The Blair government in 1999 embarked on quite an ambitious programme of activities to address inequities in health. It is very sobering indeed that by the various health status outcome measurements set up before the programme started, not a great deal has been achieved.

It is perhaps testament to successive UK governments since then that they actually commissioned the Marmot Report, *Fair Society, Health Lives* and, I understand, have been prepared to act on it. We might hear more about that later.

I need to say a final word about the New Zealand Medical Association. Since publishing the Health Equity Position Statement there have been many comments made to me and to my colleagues asking if this represents some sort of political shift within the NZMA. What we are doing here is responding to an issue that has an excellent scientific

research base, should result in improving the health of all New Zealanders, and that there needs to be a stimulus to both the Government and community for action. To that end the Position Statement does represent work as usual. Without doubt however, the NZMA may not have been quite so visible in its actions if it was not for a number of factors. The most important of these is the influence young doctors now have in the affairs of the Medical Association. Board members Dr Andrew Old and Dr Maria Poynter have been heavily involved in writing the Position Statement and providing essential support for the idea at Board level. But it is the infectious and enthusiastic idealism, that bubbles up to those of us who are not quite so young, coupled with the undoubted outstanding ability that pervades medical students and young doctors of today, that has provided the most stimulus for change. Dr Brandon Adams, and Dr Jonathon Foo have been leaders of our Doctors-in-Training Council and along with any number of members of the New Zealand Medical Students Association – we congratulate you.

There is a lesson here – how can we harness the abilities of these young people to be used in a more effective way as they proceed through their early post graduate years?

Finally, a word needs to be said about our immediate past chair – Dr Peter Foley. Without his unstinting efforts, and not a little diplomacy, this visit by Sir Michael Marmot would not have taken place.

So, enough of me let's hear from the man himself.