



Health Equity Position Statement

Definitions

<i>Health equality</i>	a description of 'sameness' in health.
<i>Health equity</i>	An ethical principle concerning the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage. ¹
<i>Health inequity</i>	the presence of systematic disparities in health between groups.
<i>Social determinants of health</i>	The conditions in which people are born, grow, live, work and age, ² including factors such as indigenous status, early life conditions, disability status, education, employment/unemployment and working conditions, food security, sex, health care services, housing, income, ethnic differences, social position and social exclusion.

This position statement uses the term *equity* in preference to *equality* because it better recognises that people differ in their capacity for health and their ability to attain or maintain health. Consequently, equitable outcomes in health may require different (i.e. unequal) inputs to achieve the same result. This is the concept of *vertical equity* (unequal, or preferential, treatment for unequals) in contrast to *horizontal equity* (equal treatment for equals).

Background

1. It is now well recognised that a society's health status is closely linked to various social determinants. Minimising the impact these social determinants have on health is now a focus of concern for many high income nations including New Zealand. Apart from the obvious societal gains from a more healthy and equitable nation, there is the potential for addressing the ever increasing cost of healthcare.³⁻⁵
2. New Zealand has a very high level of understanding of its own particular set of social determinants and through the efforts of the Ministry of Health has already made some progress in converting this knowledge into action.⁶⁻⁹
3. By many health indicators however, New Zealand continues to perform poorly when compared to other high income countries and this poor performance has direct links to our own particular set of social determinants.⁵
4. Other high income countries are currently examining this issue and England's *Fair Society Healthy Lives: Strategic Review of Health Inequalities in England post-2010*, is a recent example.³ This document culminates in a series of research driven recommendations that if adopted in full, will result in quite fundamental changes to the way England's society functions.¹⁰ Those familiar with *Fair Society Healthy Lives* will see many of NZMA's recommendations are broadly based on the set of recommendations in this document.³

5. Other significant sources for NZMA's position statement include the Australian Medical Association's *Social Determinants of Health and the Prevention of Health Inequities*¹¹, and the Royal College of Physician's policy statement, *How doctors can close the Gap: Tackling the social determinants of health through culture change advocacy and education*.¹²
6. NZMA makes no apology for the direct nature of these contributions because the characteristics of the links between the way a society functions and the health status of its people, has many international similarities. Notwithstanding these similarities, the NZMA recognises the limitations of the above documents as they apply to New Zealand's situation, and therefore has considered New Zealand-specific elements during the development of this position statement.

The Effects of Social Determinants on Health ¹³

7. Various theories have been proposed to account for the relationship between social determinants and health. Many of them have been validated by scientific observational study and can be explained by the application of fundamental biological principles.¹⁴⁻¹⁶
8. However, as with any complex socio-biological system where complete understanding of the theory and mechanisms involved is an evolving process, there continues to be debate, and even controversy, over some aspects of the understanding of just how social determinants have this effect on health.
9. A lot of interest centres on the relative contributions two different pathways related to income inequalities may contribute to health inequities.
 - a. The *material deprivation pathway* states that income inequality is related to health through a combination of negative exposures and lack of resources held by individuals, along with systematic underinvestment across a wide range of human, physical, health and social infrastructures. Examples of these include education, health services, transportation, environmental controls, availability of good quality food, quality housing, and occupational health regulations.¹³
 - b. Meanwhile the *psychosocial pathway* argues that income inequality affects health through individuals' perception of place in the social hierarchy.* These perceptions are argued to produce negative emotions such as stress, shame and distrust that are translated "inside" the body into poorer health via psycho-neuro-endocrine-immunological-genetic mechanisms and stress induced behaviours such as smoking and overeating.[†] Simultaneously, perceptions of relative position and negative emotions are translated "outside" the individual into antisocial behaviours such as violence, including homicides, traffic accidents, and reduced civic participations, which result in a loss of social capital and social cohesion within the community.¹³
10. Cardiovascular disease is a good illustration of how these two perspectives compete. Over recent decades there has been a reduction in both the incidence and mortality of cardiovascular disease. This reduction in incidence has occurred right across the social gradient. However, the *relative* reduction in incidence is far less among those at the lower end of the gradient.⁹ Most studies agree that this phenomenon is predominantly due to those at the lower end of the gradient continuing to have relatively higher rates of tobacco use and central abdominal obesity.

* Within any society there exists a social gradient and an individual's position on this gradient can be determined by various measurable factors such as income, ethnicity, education, occupation, gender and domicile.^{3,6,7,17,18}.. The position on this social gradient also has a strong influence on an individual's health status, so that those whose social determinants place them at the top of the slope enjoy a much better health status and live longer than those at the lower end of the slope. While there are a few notable exceptions, as the social gradient is traversed from top to bottom the prevalence of disease and ill-health increases.^{4,5}

† The position on this social gradient directly correlates with the incidence of mental health problems such as anxiety/depression, and drug addiction, alcoholism, tobacco use, over eating, excessive risk taking (eg as witnessed in traffic accidents), violence and homicide.^{4,5}

But, most researchers agree there is still a 20% difference not accounted for by traditional risk factors, and this difference appears to be due to the effects of social determinants. Therefore, addressing tobacco use and obesity in low gradient groups will require some intervention at the social determinant level in addition to simply promoting smoking cessation and diet modification.^{19, 20} A *material deprivation pathway* approach to this would include strategies such as decreasing GST on healthy food to promote healthier food consumption (e.g. with decreased fat intake), or banning smoking in public places or cars. A *psychosocial pathway* approach would attempt to decrease income inequality across society, so that the negative emotions associated with a low income status are felt less acutely by low income members, and consequently more positive social indicators such as social cohesion are shown.

Ethnicity

11. In New Zealand, Māori have poorer health than non-Māori across many measures, including heart disease, cancer and mortality.^{21, 22} This persists when other factors such as socioeconomic status and smoking have been controlled for.²³ Explanations for this are multi-factorial.²⁴⁻²⁶
12. In addition, pacific people and many immigrant groups are often found at the lower end of the social gradient and have a correspondingly lowered health status.⁶

Life Course Effects

13. There is universal agreement that many of the socially determined health inequities are strongly influenced, if not caused by, the environmental circumstances at the beginning of life including the fetus' in-utero experience.¹⁶
14. A child's early life experiences, including whether they are brought up in a nurturing environment, have good exposure to language development, and develop social skills also has a critical effect. Conversely, a child's exposure to overwhelming stress, emotional neglect, violence – whether witnessed or endured- or even environmental uncertainty has a profound influence on the incidence of a number of diseases in later life and mental health problems.
15. Finally, if through their life course, people are exposed to an unacceptably high number of negative environmental and social circumstances, these negative experiences accumulate and eventually affect health status.
16. These three different ways in which circumstances of the life course can affect subsequent health inequities (as outlined in clauses 13-15) have been labelled the *latent, pathway and cumulative* effects.¹⁶

The Need for Action

17. Action taken to reduce health inequities through action on the social determinants of health will benefit society in many ways. It will have a profound effect on the quality and longevity of life for everyone, and not just those at the bottom of the gradient, those who suffer the most from material deprivation, or those who are exposed to negative life course events. There is also a profound effect for the economy. Productivity losses through illness, societal costs associated with effects of mental illness, violence, including the costs of law enforcement and incarceration, numbers of people receiving benefits should all be decreased.¹
18. The ever increasing costs of healthcare are, in part at least, a result of increased treatment costs for conditions that could have been largely prevented through action on the social determinants of health. Addressing the social determinants of health is not just a way to achieve better health equity, but a critical measure to ensure the financial sustainability of the health system. Action on the social determinants of health should therefore be a major focus for the health sector.
19. However, most of the social determinants of health lie beyond the mandate of the health sector. Actions are required in many non-health sectors, including local government, social development,

transport, finance, education and justice. The health sector has a role in advocating for and actively encouraging inter-sectoral approaches to addressing the social determinants of health and the whole of society needs to be involved along with the whole of government.

Position Statement

The NZMA:

20. Believes that in order to eliminate inequities in health a whole of government approach will be required. In particular, policies addressing education, employment, poverty, housing, taxation and social security should be assessed for their health impact.
21. Believes that economic growth should not be viewed as the sole measure of a country's success and that the fair distribution of health, well-being and environmental and social sustainability are equally important goals.
22. Calls on the government to recognise that while addressing health inequities is primarily a human rights issue, doing so is also cost effective in the long term. Inaction on the social determinants of health, and hence worsening health inequities, threatens to undermine economic growth.
23. Notes that tackling the social determinants that underlie health inequity, and tackling climate change, often require similar decisions and actions. This synergy of purpose needs to be recognised and exploited.
24. Urges the government to, wherever possible, introduce the concept of proportional universalism into all its social policies: this is action that benefits all members of society, but preferentially benefits those who experience more suffering.
25. Calls on the government to continue to urgently address the inequities in health status experienced by Māori, Pacific Island Peoples, refugees, migrants and other vulnerable groups. These health inequities are compounded by inequities in exposure to risks, in access to resources, and opportunities to lead healthy lives.
26. Supports the move to totally ban cigarette sales by 2020, and supports research-proven initiatives, such as removing GST from healthy food, that promote the increased consumption of healthy food.
27. Calls for the government to adopt the following policy objectives as set out in the 'Marmot Review'³:
 - a) Give every child the best start in life.
 - i) Reduce inequities in the early development of physical and emotional health, and cognitive, linguistic and social skills.
 - ii) Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.
 - iii) Build the resilience and well-being of young children across the social gradient.
 - b) Enable all children young people and adults to maximise their capabilities and have control over their lives:
 - i) Reduce the social and ethnic gradient in skills and qualifications.
 - ii) Ensure that schools, families and communities work in partnership to reduce the gradient in health, well being and resilience of children and young people.
 - iii) Improve the access and use of quality life long learning across the social gradient.
 - c) Create fair employment and good work for all:

- i) Improve access to good jobs and reduce long term unemployment across the social gradient.
 - ii) Make it easier for people who are disadvantaged in the labour market to obtain and keep work.
 - iii) Improve the quality of jobs across the social gradient.
- d) Ensure a healthy standard of living for all:
- i) Establish a minimum income for healthy living for people of all ages.
 - ii) Reduce the social gradient in the standard of living through reducing income inequities.
 - iii) Reduce the 'cliff edges' faced by people moving between benefits and work.
- e) Create and developing healthy and sustainable places and communities:
- i) Develop common policies to reduce the scale and impact of climate change and health inequities.
 - ii) Improve community capital and reduce social isolation across the social gradient.
- f) Strengthen the role and impact of ill health prevention:
- i) Prioritise prevention and early detection of those conditions most strongly related to health inequities.
 - ii) Increase availability of long-term and sustainable funding in ill health prevention across the social gradient.
28. Urges the government to include in its deliberations the recommendations of the recently released *The Best Start in Life: Achieving effective child health and wellbeing*,²⁷ In particular the NZMA calls on the government to do the following in order to improve the access and use of quality life-long learning across the social gradient:
- strengthen leadership to champion child health and wellbeing
 - develop an effective whole-of-government approach for children
 - establish an integrated approach to service delivery for children
 - monitor child health and wellbeing using an agreed set of indicators.

Issues for the Health Sector

29. Recognises that the health system itself is a determinant of health, and of health inequities, and calls for continued efforts to reduce the contribution that health services make to health inequities in New Zealand.
30. Believes that there should be adequate consideration of health in the decisions taken in non-health sectors, to ensure that wider initiatives maximise the potential for health gains, and do not harm health, or exacerbate health inequities. The health sector has a role in advocating for this, and assisting other sectors in assessing health impacts of their policies. The *Health Equity Assessment Tool* can be used for this purpose.²⁸
31. Believes that health inequities should be routinely monitored and reported upon in the health system, and that more health inequities research needs to be carried out. This needs to be aimed at applying what is understood from observational studies and delivering meaningful knowledge to policy makers based on real-life interventions. Converting efficacy into effectiveness is paramount.²⁹
32. Believes that all health professionals should be supported and encouraged to act, advise and advocate for action on social determinants of health throughout the population, in addition to concentrating on treating individual patients.

Issues for the Medical Profession

33. Urges all medical practitioners in the course of doctor-patient consultations to discuss the underlying causes of ill health and signpost patients towards appropriate support and services, both inside and outside the health sector.
34. Urges the medical colleges to consider the impact of social determinants on health, and health inequities, and introduce specific educational goals for their fellows and trainees.
35. Urges clinical doctors and public health specialists to work together more closely in shaping services and developing programmes to promote and protect people's health, prevent ill health and tackle health inequities, and address the broader social and environmental factors that are influencing individuals' health, choices and behaviour.
36. Calls for doctors to work more innovatively and collaboratively to develop systems to reduce health inequities. Doctors must be given adequate resources including finances, information and time to do this.
37. Encourages those involved in developing practice and clinical guidelines to consider the reduction of health inequities as a key component of such work.

Issues for Medical Education

38. Believes that learning in respect of health promotion, health inequities, disease prevention and the social determinants of health needs to be made maximally engaging, be embedded as a vertical strand throughout medical education and be considered as a key outcome of medical school education.
39. Calls for senior medical figures and medical educators to legitimise, encourage and harness the power of student advocacy and action on the social determinants of health.
40. Believes that the structure of postgraduate medical training of all doctors must be examined, to see how opportunities to engage with the social determinants of health can be better incorporated through practice, research and secondments.

References

1. Braveman P, Gruskin S. Defining equity in health. *J Epidemiol Community Health* 2003;57:254-8.
2. CSDH. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organisation; 2008.
3. Marmot M. Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010 (The Marmot Review). London: The Marmot Review; 2010.
4. Marmot M. The Status Syndrome. New York: Times Books; 2004.
5. Wilkinson R, Pickett K. The Spirit Level: why greater equality makes societies stronger. New York: Bloomsbury Press; 2009.
6. Blakely T, Tobias M, Atkinson J, Yeh L-C, Huang K. Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981-2004. Wellington: Ministry of Health; 2007.
7. Robson B, Purdie G, Cormack D. Unequal Impact II: Māori and Non-Māori Cancer Statistics by Deprivation and Rural-Urban Status, 2002-2006. Wellington: Ministry of Health; 2010.
8. Joshy G, Simmons D. Epidemiology of diabetes in New Zealand: revisit to a changing landscape. *New Zealand Medical Journal* 2006 Jun 2;119(1235).
9. Chan W, Wright C, Riddell T, et al. Ethnic and socioeconomic disparities in the prevalence of cardiovascular disease in New Zealand. *New Zealand Medical Journal* 2008 Nov 7;121(1285).
10. Hunter D, Popay J, Tannahill C, Whitehead M. Getting to Grips with health inequalities at last? [Editorial]. *British Medical Journal* 2010;340:c684.
11. Australian Medical Association. Social determinants of health and the prevention of health inequalities [position statement]. Sydney: Australian Medical Association; 2007.
12. Royal College of Physicians. How doctors can close the gap. RCP policy statement. London: Royal College of Physicians; 2010.
13. Lynch J, Smith G, Kaplan G, House J. Income inequality and mortality: importance to health of individual income, psychosocial environment, or material conditions. *British Medical Journal* 2000;320(7243):1200-4.
14. Caspi A, Sugden K, Moffitt TE, et al. Influence of Life Stress on Depression: Moderation by a Polymorphism in the 5-HTT Gene. *Science* 2003;301(5631):386-9.
15. Crews D, McLachlan JA. Epigenetics, Evolution, Endocrine Disruption, Health, and Disease. *Endocrinology* 2006;147(6):s4-10.
16. Shonkoff JP, Boyce WT, McEwen BS. Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities: Building a New Framework for Health Promotion and Disease Prevention. *JAMA* 2009;301(21):2252-9.
17. Van Rossum C, Shipley M, van d Mheen H, Grobbee D, Marmot M. Employment grade differences in cause specific mortality. A 25 year follow-up of civil servants from the First Whitehall Study. *J Epidemiol Community Health* 2000;54:178-84.
18. Wilkinson R, Pickett K. Income inequality and population health: A review and explanation of the evidence. *Soc Sci Med* 2006;62(7):1768-84.
19. Kawachi I, Subramanian SV, Almeida-Filho N. A glossary for health inequalities. *Journal of Epidemiology and Community Health* 2002;56(9):647-52.
20. Kivimäki M, Shipley M, Ferrie J, et al. Best-practice interventions to reduce socioeconomic inequalities of coronary heart disease mortality in UK: a prospective occupational cohort study. *The Lancet* 2008;372(9650):1648-54.
21. Ministry of Health. A Portrait of Health: Key results of the 2002/03 New Zealand Health Survey. Public Health Intelligence Occasional Bulletin No 21. Wellington: Ministry of Health; 2004.
22. Ministry of Health. Decades of Disparity: ethnic mortality trends in New Zealand 1980-99. Wellington: Ministry of Health; 2003.
23. Reid P, Robson B, Jones C. Disparities in health: common myths and uncommon truths. *Pacific Health Dialog* 2000;7(1):38-47.
24. Harris R, Tobias M, Jeffreys M, Waldegrave K, Karlsen S, Nazroo J. Effects of self-reported racial discrimination and deprivation on Maori health and inequalities in New Zealand: cross-sectional study. *Lancet* 2006;367(9257):2005-9.
25. Reid P, Robson B. Understanding health inequities. In: Robson B, Harris R, eds. *Hauora: Maori Standards of Health IV A study of the years 2000-2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare; 2007.
26. Secretariat of the Permanent Forum on Indigenous Issues. State of the World's Indigenous Peoples. New York: United Nations; 2009 ST/ESA/328.
27. Public Health Advisory Committee. The Best Start in Life: Achieving effective action on child health and wellbeing. Wellington: Ministry of Health; 2010.
28. Ministry of Health. A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health. Wellington: Ministry of Health; 2004.
29. Glasziou P, Haynes B. The paths from research to improved health outcomes. *Evidence Based Medicine* 2005;10(1):4-7.