Closing the gaps: health equity by 2040

Lyndon Keene, Sarah Dalton

The main goals of the "once in a generation" Health and Disability System Review, which has led to a major system restructuring that's now in its early stages, included better health outcomes for all and greater health equity, despite the review accepting that most of a person's health status is determined by factors outside the system. In July this year, the Association of Salaried Medical Specialists (ASMS) and the Christchurch Charity Hospital Trust (CCHT) co-hosted a conference of health professionals to discuss the broader range of policies that are needed to address health inequities and improve health outcomes for all. This article outlines some of the key issues and recommendations to government emanating from that conference and contained in our report, *Creating Solutions Te Ara Whai Tika: a roadmap to health equity by 2040*.

Health inequities

Health inequities have existed in New Zealand since records began. They have been described as immoral because for many years governments have known what is needed to address them. Two decades ago, the New Zealand Health Strategy 2000 included the goal of addressing health inequities as priority, recognising the "clear international evidence" supporting policies focusing on the broad economic and social determinants of health, including access to healthcare.[1]

There have been some improvements, such as a drop in the number of smokers, but in general the public health issues requiring attention today are the same ones identified in 2000. In the period 2005–2007, average life expectancy at birth for Māori males was 8.6 years less than for European/other males; for females the gap was 8.1 years. By the period 2017–2019 the gaps had narrowed by just 1.3 years and 0.7 years.[2]

The life expectancy gap between Pasifika and European/other in 2017–2019 was 5.6 years for males and 5.5 years for females—an improvement of 0.5 years and 0.3 years respectively over the 12-year period.

At this rate of progress, Māori males would achieve equity in life expectancy with European/other males by around 2090—approximately 70 years. For Māori females and Pasifika males, equity with European/other would not be achieved until well into the 22nd century—approximately 127 years and 134 years, respectively. Pasifika females would need to wait approximately 220 years.

Comparisons of life expectancy between the poorest and wealthiest New Zealanders over the same 12-year period show a widening gap. In 2005–2007, males in the wealthiest decile could expect to live 7.2 years longer than those in the poorest decile. By 2017–2019 the gap had widened to 10.6 years. Life expectancy gaps for females were 5.4 years in 2005–2007 and 9 years in 2017–2019.

The widening gaps are owing to a life expectancy increase in the wealthiest groups, especially over recent years, and a drop in the life expectancy of the poorest groups (including a disproportionate number of Māori) in recent years.

It is well recognised that health, well-being and equity are strongly influenced by the socioeconomic, political and cultural environments that people are exposed to. This includes the quality of education, food, housing, employment, transport and physical environment, along with factors such as race, gender and social exclusion. Also, as emphasised by the World Health Organization (WHO), health is influenced by the distribution of power, money and resources, which influence conditions of everyday life.[3]

Research has found the health status of different groups classified by deprivation produce social gradients where the more deprived the neighbourhood the worse the

health—and worse still when the effects of institutional racism and cultural alienation are added to the mix.[4,5]

In New Zealand, health inequities have been exacerbated by widening income gaps in large part owing to the ongoing cumulative effects of the economic downturn in the 1970s, the neoliberal policies introduced in the 1980s and benefit cuts in the 1990s. Between 1985 and 2013 New Zealand had one of the biggest increases in income gaps among developed countries in the OECD.[6]

Although the government announced in this year's budget a hike in the weekly main benefit rates, by between $32 and $55 per adult, as part of its stated commitment to addressing poverty, an analysis of the budget by the Child Poverty Action Group found few families receiving benefits will be lifted over the poverty line. With the changes announced in the budget, Treasury forecasts that child poverty will reduce from 18.4% to only 17.0% by 2023.[7,8]

In other areas highlighted in our report, the urgent need for more housing—and especially health housing—continues to grow faster than the government can build. The government's state house build programme well exceeded its plan to build or acquire 2,282 houses in the year to June 2021. However, the growing demand for housing is far outstripping new supply. Well over 24,000 households were on the public housing waiting list in June this year. Meanwhile, rents continue to rise steadily across the country.[9,10]

In education, according to UNICEF, New Zealand has one of the most unequal systems in the world and the gap between the highest and lowest performing students is being made worse by poverty. In its 2018 Innocenti Report Card, UNICEF ranked New Zealand 33rd out of 38 countries for educational inequality across preschool, primary school and secondary school levels. The report's author commented that under-resourced and stressed families and communities, combined with racism and bias in the educational system, contributed to these inequities.[11]

Health inequalities for Māori are characteristic of Indigenous peoples in colonised countries, even when socioeconomic factors are considered. The underlying causes reflect systematic social, political, historical, economic and environmental factors, accumulated during a lifetime, and transferred across multiple generations. For individuals, they lead to cultural misunderstanding, unconscious bias and racism.[12–15]

To the extent that health professionals engage with patients with positive intent, misperception and lack of connection between patients from non-dominant ethnic groups and medical professionals is not uncommon. Studies have consistently demonstrated that doctors treat Māori differently from non-Māori to their detriment. Lack of cultural awareness, latent biases and institutional racism lead to poorer health outcomes.[16]

The health system itself is inaccessible to many. Around 1 in 8 European/other adults and 1 in 5 Māori and Pasifika adults report an unmet need for a GP service due to cost. As a conservative estimate, nearly 1 in 10 people have an unmet need for hospital care.[17,18]

The Health and Disability System Review acknowledges "the system is facing severe workforce shortages for some professions." The Covid-19 pandemic has revealed the fragility of the thin white line that separates a safe system from an unsafe one.

The planned health system restructuring, depending on the yet-to-be-announced detail, may go some way to addressing health inequities and facilitate more consistent access to services nationwide and enable better integration of services. However, given most of the solutions to good health lie outside the health system, the efforts to improve the effectiveness of health services are likely to struggle to make significant headway until the broader determinants of ill-health are addressed.

Is health equity achievable?

In all societies there will be the poor, relatively and absolutely. All societies have social and economic inequalities. Which raises the question: if the health-needs gradient arises because of these inequalities, won't there always be health inequities?

Sir Michael Marmot, one of the world's leading authorities on health equity and a keynote speaker at the ASMS-CCHT conference, responds to this question with

evidence that the health of those most in need can be improved markedly over 10 years. The hitch is that at the same time the health of those least deprived also tends to improve at approximately the same rate, so the health equity gap remains. Says Marmot: "The lesson I take from this is that if the health of the poor can be improved quickly, then there is nothing fixed about inequalities in health. The fact that the slope of the health gradient did not change despite overall improvements in health suggests we need to look upstream to social determinants of health inequity."[19]

In addition, while all societies do have social gradients in health, the slope varies. A European review of health inequalities that looked at life expectancy at age 25 found Central and European countries had low average life expectancy and big inequalities. Sweden, Norway and Mediterranean countries had long average life expectancy and smaller inequalities. Says Marmot: "We need to move from an Estonian and Hungarian level of health inequity to a Nordic or Mediterranean level… We [the Marmot Review] were convinced by the evidence that one of the secrets to good health in Nordic countries is a commitment to universalism."[20,21]

Proportionate universalism, the approach introduced in the Marmot Review, involves universal interventions that are implemented with a scale and an intensity that is proportionate to the level of need across the social gradient as opposed to solely targeting the least disadvantaged groups, a common response from governments focused on cost-containment. This approach aims to improve the health of the *whole* population while simultaneously improving the health of the most disadvantaged fastest.

The solutions

Proportionate universalism is gaining a lot of international attention, including in New Zealand. A 2018 cabinet paper co-signed by Prime Minister and Minister for Child Poverty Reduction Jacinda Arden, proposing a child wellbeing strategy, explained: "A programme of joined-up (across sector *and* life-stages) evidence-based interventions supported by the state… and delivered according to proportionate universalism principles, is empirically supported." Consequently, the Child and Youth Wellbeing Strategy, released in 2019, takes a proportionate universalism approach. So why not adopt this approach for the whole population?[22]

The approach "implies a need for action across the whole of society, focusing on those social factors that determine health outcomes." It requires a whole-of-government response with strong partnerships across six key areas: early child development, education, employment and working conditions, having enough money to live on, healthy environments in which to live and work, and a social determinants approach to prevention. This in turn requires great investment in the health system and in addressing the social determinants of ill health.

To put this into context: to follow the Nordic approach, as recommended by Marmot, New Zealand would need to lift its public social spending (including health spending) from around 19% of GDP to around 25%, based in 2019 data.[23]

This would require political leaders, policymakers and local management to relinquish old ways of thinking and stop viewing health services in narrow financial terms, as an expenditure that needs to be controlled. Rather, they need a broader social and economic perspective that recognises the overwhelming evidence for investing in health for potentially substantial social and economic gains.[24–29]

As the United Nations' High-Level Commission on Health Employment and Economic Growth points out that not only is investment in health good for population health and wellbeing, but that the health sector is also a key economic sector, a job generator and a driver of inclusive economic growth.[30]

With the right level of investment to match the government's vision for New Zealanders' wellbeing, addressing challenges such as those outlined above becomes much more achievable.

The aim of improving the standards of living of those most in need would be greatly advanced, for example, if benefits are set so people who depend on them are not living in poverty, and if the minimum wage is set at the same level as the voluntary "living wage."[31]

Pressures on young families would be lifted if the current policy of 20 hours of free early childhood education (ECE) for 3–5-year-olds is extended to 1–2-year-olds as a first step towards addressing the cost barriers to accessing ECE in New Zealand, which UNICEF reports is among the most unaffordable in a list of 41 countries.[32]

In education, we recommend that policies are introduced for schools to close the gaps in educational performance between the lowest and highest educational performers. Solutions include fairer distribution of high-quality learning across different communities, increasing resources and reducing stress in families and communities. There is also an urgent need for significant improvement in health literacy and health competencies, which should be addressed early on in schools.

In housing there is no silver bullet to solve multiple issues. Many things need to happen at once, but there is a common view that much greater public investment is needed along with stronger measures to ensure compliance with healthy homes standards, including a mandatory rental housing "warrant of fitness."

In the health sector, although free access to GPs for under-14s has improved primary care access for children, many adults continue to miss out, in part because of the service fees. Those with the greatest need (ie, the poorest groups, Māori and Pasifika) have higher preventable hospitalisation rates than other groups. Accordingly, we recommend abolishing user charges for primary care. Alternative funding arrangements for GPs are needed that ensure incomes are not negatively affected. Other cost barriers (such as prescription charges, travel costs and dental fees) also require attention, and solutions will necessarily involve social welfare and other sectors.

Improving access to hospital care requires, as a first step, regular independent and comprehensive population surveys of unmet need for hospital services, with funding decisions being based on meeting those needs. Without such information, how can we know how well the system is performing?

A comprehensive health and disability workforce plan is critical for informing the investment needed to address workforce shortages, education, training, distribution, recruitment and retention, along with workforce equity and diversity. Training places for health professionals must be increased, based on a workforce census and current and forecast health and disability needs.

There is strong international consensus that, to meet the challenges facing today's healthcare systems, traditional top-down managerial leadership approaches are not fit for purpose. A new type of leadership, which is distributed to those with intimate knowledge of the day-to-day workings of healthcare, is needed. These leaders—healthcare professionals—are best placed to understand how to improve organisational performance and influence care practices.

We recommend that health policies support a leadership model to nurture a collaborative culture and create conditions in which responsibility, power and decision-making are distributed throughout organisations and communities rather than a "top-down" hierarchy.

To help address ethnic health disparities, we call on the government to require public health and social organisations to demonstrate how they are supporting health professionals to achieve culturally safe practice and address racism. Adequate resources must be provided for all government services to achieve cultural safety at every level, including sufficient staffing to allow time for learning and self-reflection.

To gain a better understanding of ethnic disparities and to monitor the effects of government policies that impact on them, the collection, monitoring, analysis and reporting of quality ethnicity data, from both organisational performance and workforce perspectives, must be substantially improved.

Other recommendations towards the overriding aim to achieve health equity by 2040 include ways to: improve whole-of-government collaboration to effectively implement wellbeing policies; strengthen actions concerning the impact of climate change on health; improve government accountability for delivering on policies; strengthen policies to address the commercial determinants of ill health; establish an independent health commission; and make health impact assessments mandatory, supporting "Health in All Policy" approaches.

Finally, an important issue that is not included in the report (as it is targeted at the government) concerns conference discussions around health advocacy. Feedback from conference discussion groups reasoned that governments will invest in and implement the transformational changes that are needed to improve health outcomes for all and achieve health equity if there is strong public support to do so, and this requires widespread public discussion. Health professionals, who see the effects of the determinants of ill health every day, are in a strong position to foster such public debate.

A key aim of *Creating Solutions Te Ara Whai Tika,* in addition to making recommendations to government, is to help stimulate that debate. It is available on the ASMS and CCHT websites.[33]

Competing interests:
Nil.
Acknowledgements:
Creating Solution Te Ara Whai Tika was produced following the presentations and discussions from the virtual conference, Creating Solutions: Towards better health equity for all, held on 2-3 July 2021, the brainchild of Canterbury Charity Hospital trust founders Phil Bagshaw and Dame Sue Bradshaw. We are especially grateful to them for their collaboration on these projects. We would also like to acknowledge the conference patron Sir Jerry Mateparae GNZM, QSO, KStJ, the conference speakers and all the participants who took part in the discussions and provided valuable feedback. Finally, we wish to acknowledge Dr Lloyd McCann and Mercy Radiology who generously sponsored the conference.
Author information:
Lyndon Keene: Health policy analyst, ASMS.
Sarah Dalton: Executive Director, ASMS.
Corresponding author:
Lyndon Keene, C/- ASMS, PO Box 10763, The Terrace, Wellington, 6143, Wellington, New Zealand
lk@asms.org.nz
URL:
www.nzma.org.nz/journal-articles/closing-the-gaps-health-equity-by-2040

REFERENCES

1. Health and Disability System Review. Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington: HDSR, 2020.
2. Statistics New Zealand [Internet]. Period life tables 2017-19 [cited 2021 Sep]. Available from: https://www.stats.govt.nz/information-releases/national-and-subnational-period-life-tables-2017-2019
3. WHO Commission on Social Determinants of Health. Closing the gap in a generation: Health equity through action on the social determinants of health, WHO Press, Geneva, 2008.
4. Marmot M. Fair Society, Healthy Lives: The Marmot Review: Strategic review of health inequalities in England post-2010. London: The Marmot Review.
5. Marmot, M. The health Gap. London: Bloomsbury, 2015
6. Keeley, B, Income Inequality: The Gap between Rich and Poor, OECD Insights, OECD Publishing, Paris, 2015. Available from: http://dx.doi.org/10.1787/9789264246010-en
7. NZ Government. Child Poverty Report: Wellbeing Budget 2021, 20 May 2021.
8. Child Poverty Action Group [Internet]. CPAG Budget Analysis, 20 May 2021. Available from: https://www.cpag.org.nz/resources/budget/
9. NZ Government [Internet]. Housing Package Detail [cited 2021 Jul]. Available from: https://www.beehive.govt.nz/sites/default/files/2021-03/Housing%20Package%20Detail.pdf
10. Ministry of Housing & Urban Development [Internet]. Public Housing Reports [cited 2021 Sep]. Available from: https://www.hud.govt.nz/news-and-resources/statistics-and-research/public-housing-reports/
11. UNICEF. An Unfair Start: Inequality in Children's Education in Rich Countries, Innocenti Report Card 15, UNICEF Office of Research – Innocenti, Florence, 2018.
12. Simpson J, Duncanson M, et al. Te Ohonga Ake: The Health Status of Māori Children and Young People in New Zealand, Series Two, University of Otago, April 2017.
13. Howden-Chapman P, Tobias M. Social Inequalities in Health: New Zealand 1999. Wellington: Ministry of Health, 2000.
14. Smedley B, Stith A, Nelson A (eds). Unequal treatment: Confronting racial and ethnic disparities in health care. Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care: Board on Health Sciences Policy, Institute of Medicine. Washington, DC: National Academics Press, 2002.
15. Pulver L, Haswell M, Ring I, et al. Indigenous Health – Australia, Canada, Aotearoa New Zealand and the United States – Laying claim to a future that embraces health for us all, World Health Report, Background Paper, 33, WHO, December 2010.
16. ASMS. Path to Patient Centred Care. Health

Dialogue, Issue 15, March 2018, pp 26-31.

17. Ministry of Health [Internet]. New Zealand Health Survey 2019/20 [cited 2021 Sep]. Available from: https://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/new-zealand-health-survey
18. Bagshaw P, Bagshaw S, Frampton C, et al. Pilot study of methods for assessing unmet secondary health care need in New Zealand. NZMJ. 2017;130(1452):23-38.
19. Marmot, M. Social justice, epidemiology and health inequalities. Eur J Epidemiol **32,** 537–546 (2017). Available from: https://doi.org/10.1007/s10654-017-0286-3
20. Marmot M (Consortium Lead). Health inequalities in the EU—Final report of a consortium. 2013.
21. Eurostat [Internet]. Life expectancy by age, sex and educational attainment (ISCED 1997) 2012 [updated 2012/07/27/]. Available from: http://appsso.eurostat. ec.europa.eu/nui/show.do?dataset=demo_mlexpecedu&lang=en.
22. Office of the Minister for Child Poverty Reduction and Office of the Minister for Children. Child Wellbeing Strategy – Scope and Public Engagement Process: Proposal for the Cabinet Social Wellbeing Committee, 6 August 2018.
23. OECD Social Spending Data [cited 2021 Sep]. Available from: https://data.oecd.org/socialexp/social-spending.htm
24. Ministry of Health. The cost and value of employment in the health and disability sector. Wellington: Ministry of Health, 2020.
25. Dalziel P, Cameron T. Wellbeing Economics. Global Public Health. Published online 23 February 2021. Available from: https://doi.org/10.1093/acrefore/9780190632366.013.312
26. Dalziel P, Saunders C, Saunders J. Wellbeing Economics: The capabilities approach to prosperity, Palgrave Macmillan, 2018.
27. Monterubbianesi P, Grandes M, et al. New evidence of the health status and economic growth relationship, January 2016 Panoeconomicus. 64(00):20.
28. WHO. Healthy, prosperous lives for all: the European Health Equity Status Report. Copenhagen: WHO Regional Office for Europe, 2019.
29. Reeves A, Basu S,McKee M, et al. Does investment in the health sector promote or inhibit economic growth? Globalization and Health 2013, 9:43.
30. HLC. Working for health and growth: investing in the health workforce. Report of the High-Level Commission on Health Employment and Economic Growth. Switzerland: World Health Organisation, 2016.
31. Living Wage Movement Aotearoa New Zealand [Internet]. Available from: https://www.livingwage.org.nz/
32. UNICEF. An Unfair Start: Inequality in Children's Education in Rich Countries, Innocenti Report Card 15, UNICEF Office of Research – Innocenti, Florence, 2018.
33. ASMS-CCHT. Creating Solution Te Ara Whai Tika: A roadmap to health equity 2040. Association of Salaried Medical Specialists and the Christchurch Charity Hospital Trust, September 2021. Available from: https://issuu.com/associationofsalaried-medicalspecialists/docs/asms-creating-solutions-fa-web_-_final and https://charityhospital.org.nz/health-equity-achievable/