

Country Case Study; New Zealand

Dialogue on Intersectoral Action.

Health inequalities: unfair, measurable and remediable? The case of New Zealand

Paper prepared for the WHO Commission on Social Determinants of Health

In the last decade, social and health inequalities have moved to the centre of the policy environment in New Zealand. From an absence of general discussion about disparities between groups, awareness has increased to the extent that inequalities are now a significant part of the political debate for the major political parties and central to the policy development and monitoring frameworks, particularly in the health sector. This paper considers how this development has occurred with regard to health and presents initial indicators of the progress made, exploring why New Zealand chose to act on health inequalities and how this has been implemented.

The paper provides a brief overview of health inequalities in New Zealand followed by a discussion of relevant local literature and tools to address these inequalities. Intersectoral action as part of a ‘whole of government’ approach to inequalities has been a key element of implementation efforts, and an intersectoral housing project to improve health is described to illustrate this. The paper concludes with a consideration of the impact of the policy attention to inequalities and further challenges for New Zealand to continue progress in this area.

It should be noted that the term ‘inequalities in health’ as used in New Zealand carries connotations of socially produced disparities that are unfair. Such disparities might be described as ‘health inequities’ in other regions. In this sense, the New Zealand usage is similar to that in the United Kingdom and other parts of Europe.¹ Throughout this paper, ‘inequalities in health’ and ‘health inequalities’ are used in this way, reflecting the New Zealand context.

Inequalities in health in New Zealand

There is now a large literature and research base on health inequalities in New Zealand. The major focus, reflecting the major inequality, has been on ethnic inequalities. Analysis has been made possible by the National Health Index (NHI, a unique identifier for individuals in the health system), greater attention to the measurement of ethnicity in the health sector and new tools such as the linkage of census data to health records.

Māori, the indigenous people of New Zealand, have worse health status than non-Māori New Zealanders across almost all health indicators. There is an eight year life expectancy gap between Māori men and non-Māori men and a nine year life expectancy gap between Māori women and non-Māori women.² Māori have poorer access to health services, poorer quality of care within the health system and worse health outcomes for most disease groups.³

It is estimated that at least half of the life expectancy gap between Māori and non-Māori is explained by socio-economic disparities, as Māori are heavily over-represented in low socio-economic groups.⁴ However, evidence exists to show that Māori suffer worse health compared to non-Māori of similar socio-economic status and furthermore that Māori in high socio-economic groups have worse life expectancy than non-Māori in low socio-economic groups.^{5,6} Māori have much higher rates of smoking than non-Māori (approximately 50% current smoking prevalence versus 20%) and this is thought to explain around 10% of the mortality gap.⁷ The experience of racial discrimination (both inside and outside of the health sector) and related poorer access to and quality of health services are postulated to explain most of the remaining life expectancy gap.^{8,9}

Other minority groups in New Zealand also experience poorer health than the majority New Zealand European population, although not to the same extent as Māori. Pacific peoples in New Zealand (people who migrated to New Zealand mostly since the Second World War from the islands of the Pacific, and their descendents) also exhibit a large life expectancy gap (approximately five years).¹⁰ Pacific peoples in New Zealand have the worst socio-economic status of any of the major ethnic populations, including Māori.

Asian peoples in New Zealand (in the New Zealand health sector, people who migrated from the Asian continent south and east of Afghanistan inclusive, and their descendents)¹¹ now comprise almost one-tenth of the population, following increased immigration over the last twenty years, and show a paradoxical picture in terms of health inequalities. Due to the 'healthy migrant' phenomenon,¹² Asian peoples tend to show similar or higher life expectancy compared with European New Zealanders, but at the same time report poorer access to health services and high levels of chronic disease, such as diabetes and cardiovascular disease, in some Asian ethnic groups such as Indians.¹³

Socio-economic health inequalities have also been well investigated in New Zealand.¹⁴ There is no doubt that major inequalities exist and that these inequalities, as with ethnic inequalities, widened following the economic structural reforms of the 1980s and early 1990s (as described further below). Life expectancy gaps between the most deprived and most affluent quintiles are around 9 years for males and 7 years for females.¹⁴ All ethnic

groups in New Zealand exhibit socio-economic gradients in health, although the gradient is relatively shallow for Asian and Pacific peoples and steep for Māori and European ethnic categories.¹⁵

Other dimensions of health inequalities, such as dimensions of gender and place of residence, have received less attention in New Zealand. Females in New Zealand show similar advantages compared to males in life expectancy as seen in other developed countries (mainly due to lower levels of cardiovascular mortality), but this gender difference has so far attracted little policy attention. Conversely, there remain inequalities for women in some ethnic groups in access to and quality of health services, as, for example, shown by New Zealand's experience with implementing screening programmes. There is also evidence of geographical disparities in health in New Zealand. These are mediated by the socio-economic and ethnic inequalities described above, but also by differential access to services and health selective migration, as in other countries.¹⁶

In summary, detailed evidence is now available in New Zealand about health inequalities in terms of ethnicity and socio-economic status, and there is some information available about gender and geographical disparities. As in other countries, all of these dimensions of inequality (along with others) interact with each other. The development of this evidence base over the last twenty years has influenced health policy in New Zealand to the extent that it is now common to plan a health programme considering these inequalities and monitoring of impact on these inequalities is an essential part of health programme evaluation. The next section of this paper considers how this evidence base was developed and what impacts and interactions it has had with the health policy environment in New Zealand.

Impact of development of the research and policy environment about health inequalities in New Zealand

Health inequalities are now a major priority for health sector planning and monitoring in New Zealand as well as a key focus in overall social policy. Legislative and policy instruments license and enforce this focus and tools have been developed to increase awareness and workforce capacity to take action on these disparities. These advancements have been driven by the increasing evidence base, contributing to its expansion, and have occurred in a very short period of time, beginning in the late 1990s. A number of factors have contributed to moving health inequalities to a central stage in health policy, although this process is still incomplete. With regard to ethnic inequalities, these changes have mirrored increasing recognition of the Treaty of Waitangi (the compact between the indigenous Māori and European settlers signed in 1840). Allied to a growing research base about Māori health, this had led to an active discussion in academic and policy circles about the historical and contemporary contextual factors that have maintained Māori health inequalities.^{17,18,19}

The emergence of a strong focus on health inequalities can be conceptualised in terms of the different but intersecting public, political and organisational discourses around disparities in health. The public discourse in New Zealand originated from increasing concern in the 1990s around socio-economic inequalities and the threats to social cohesion that these posed. A strong egalitarian value system had operated in New Zealand around fairness of opportunity and lack of hierarchy, arising from a settler culture and New Zealand's revolutionary suffrage movements (New Zealand being the first nation to grant women the right to vote in 1893) and social welfare programmes of the 1890s and 1930s. This belief in equality often failed, however, to recognise the severe impact of colonialism on Māori, which was exacerbated by the structural reforms of the 1980s and 1990s (which disproportionately affected Māori and also Pacific peoples). Increasing anxieties about increased crime, poor economic performance and greater cultural diversity interacted with starkly rising inequalities to undermine the sense of egalitarianism by the end of these structural reforms. There was also public unease at how the reforms had not respected the egalitarian ideal but instead greatly increased inequality.

This public concern about unfairness and the impact on inequality of the structural reforms to subsidies, the labour market, public housing and benefit payments created a space in the political discourse for attention to inequalities in health, building on the growing international and local literature. The government of the National Party in its third term during 1996-1999 saw the emergence on the political agenda of the health needs of disadvantaged groups, as it tempered its market reforms of the early 1990s (which itself built on the market and social sector reforms of the previous Labour government from 1984 onwards). One outcome of this was strong government support for the delivery of health services outside of the 'mainstream' by Māori and Pacific providers.

A particularly important milestone was the publication of a report by the National Health Committee (NHC) entitled *The Social, Cultural and Economic Determinants of Health in*

New Zealand in 1998.²⁰ The NHC is an independent statutory committee appointed by the Minister of Health and mandated to provide independent advice to the Minister on health and disability issues, with an annual report tabled in Parliament. The NHC report on health determinants brought the issue of health inequalities into the health policy agenda (including identifying that they were worsening). Moreover, it provided a rationale for acting on these disparities and recommended strategies for the Minister to do so.

A parallel development during the 1990s was the development of a new methodology to describe socio-economic inequalities in New Zealand, the New Zealand Deprivation Index. This index evaluated census data using a nine point scale covering income, employment, access to communication and transport, education and property ownership to assign a deprivation score to small geographical units called meshblocks, defined across the whole country.²¹ This allowed the use of deprivation scores as proxies for socio-economic status, and subsequent analyses related these scores to health and other social indicators. The Index structured and boosted interest in socio-economic inequalities in New Zealand and provided social agencies with evidence on which they could plan funding decisions to address these inequalities. For example, in health, the funding of health authorities takes account of the Deprivation Index in the funding formula.

These advances in the public and political discourse were further built upon by the new Labour government in 1999 which came to power with a strong platform of increasing public spending in health and education. One of its key policy planks was ‘closing the gaps’ between the disadvantaged and the privileged in New Zealand society.²² This policy was aimed at all inequalities, but with additional funding and emphasis in the areas: capacity building, education, health and housing, economic and community development.

The new government implemented new health legislation and began planning a series of new health strategies (See Appendix) to be developed by the Ministry of Health and implemented by the health sector. . The *New Zealand Public Health and Disability Act 2000* comprehensively reformed the New Zealand health sector, instituting a population health focus and an explicit requirement for the health sector to reduce health inequalities. In relation to Maori, the act has two statutory requirements for active Maori participation; these are in service delivery and decision making. (Section 4 of NZPHDA) This is interpreted as having Maori members on boards, and these are appointed by the Minister if not directly elected. The Boards also have a direct relationship with local tribal authorities, and these are used as a forum to involve Maori in decisions by the board . For the Ministry of Health, its key functional documents such as its Statement of Intent and annual performance reviews now incorporated clear reference to the need for action on health inequalities.

The new Act also reconstituted the delivery of health services in New Zealand by devolving responsibility for local health status to 21 regional health authorities called ‘district health boards’. These boards were mandated to respond to the local health needs of their communities and to explicitly ensure the reduction of health inequalities. As a

result, a health inequality focus was now embedded into the delivery of all health services, from preventive to tertiary levels, at least at the policy level.

Alongside this re-orientation in the policy environment was an increase in the local academic literature around health inequalities. While work on health inequalities had been ongoing for several years in New Zealand, the late 1990s saw the beginning of more systematic evaluations, often funded and facilitated by government. Two key reference works were published by the Ministry of Health – *Social Inequalities in Health, New Zealand 1999* released in 2000 and *Reducing Inequalities in Health* released in 2002.^{23,24} The former publication firmly put health inequalities on the agenda of the health sector in an authoritative manner as the new Labour government was beginning to act on these disparities, while the latter publication provided a template for how action to reduce inequalities could be achieved.

Reducing Inequalities in Health incorporated a strong determinants of health approach. It also provided a framework (shown below in Figure 1) to consider how to reduce health inequalities by action aimed at the different levels from which these disparities resulted. The publication provided an entry point for action for health providers who had previously not seen disparities as something they could (or should) act upon – but also clearly demonstrated how action to reduce health disparities could not be implemented by health agencies acting alone.

The Ministry of Health also entered into an important partnership with an academic institution, the Wellington School of Medicine, to establish the New Zealand Census – Mortality Study, an ongoing record linkage study that links census to mortality (and more recently, cancer registration) records. This collaboration led to the publication of three volumes entitled *Decades of Disparity* which exhaustively described health inequalities in New Zealand from 1981 to 1999 (shortly to be updated to 2004). The reports provided incontrovertible evidence of the large disparities between Māori and non-Māori – conclusively showing that these disparities were partially independent of socio-economic status.^{2,4,14} These findings have been crucial in motivating the health sector to action on inequalities. Further research from many other institutions and individuals has illuminated disparities not only in health status, but also in all aspects of the treatment pathway.

The Ministry of Health also partnered with the Wellington School of Medicine to produce the Health Equity Assessment Tool (HEAT) to assist the health sector to plan programmes with due attention to health inequalities. The Tool, shown in Appendix 1, consists of a series of questions which guide planners and providers to consider the drivers of inequalities and how a new or existing programme might impact on inequalities. In particular, it encourages users to consider the unintended impacts on inequalities of new programmes. The HEAT Tool is now variably used throughout the health sector but has been central to workshops and other efforts by the Ministry and the university to increase awareness and raise skills to tackle health inequalities by the sector. It has also been used by the Families Commission, and incorporated into a Health Impact Assessment Tool²⁵ that has been used in the transport sector and by local government for

example urban growth strategies to assist in reducing health inequalities through planning and policy-making process. The Ministry of Health has recently set up a Health Impact Assessment Support Unit.

New health strategies at both national (Ministry) and local (District Health Board) levels since 2000 have reflected the new commitment to reducing health inequalities. In particular, the overarching *New Zealand Health Strategy* and *New Zealand Disability Strategy*, the Māori health strategy *He Korowai Oranga*, the *Primary Health Care Strategy*, and the *Healthy Eating, Healthy Action* physical activity and nutrition strategy have provided major impetus to progress on inequalities, with clear identification that this is a priority for both monitoring and action.^{26,27,28,29,30} The wide consultation process in the development of these strategies has been an important opportunity to increase awareness in the sector about advances in knowledge about health inequalities and mechanisms to address these. This increased commitment to reducing inequalities is now also seen in district health board plans and, more slowly, in the plans of the new primary health organisations charged with preventive and primary care services under the new strategy.

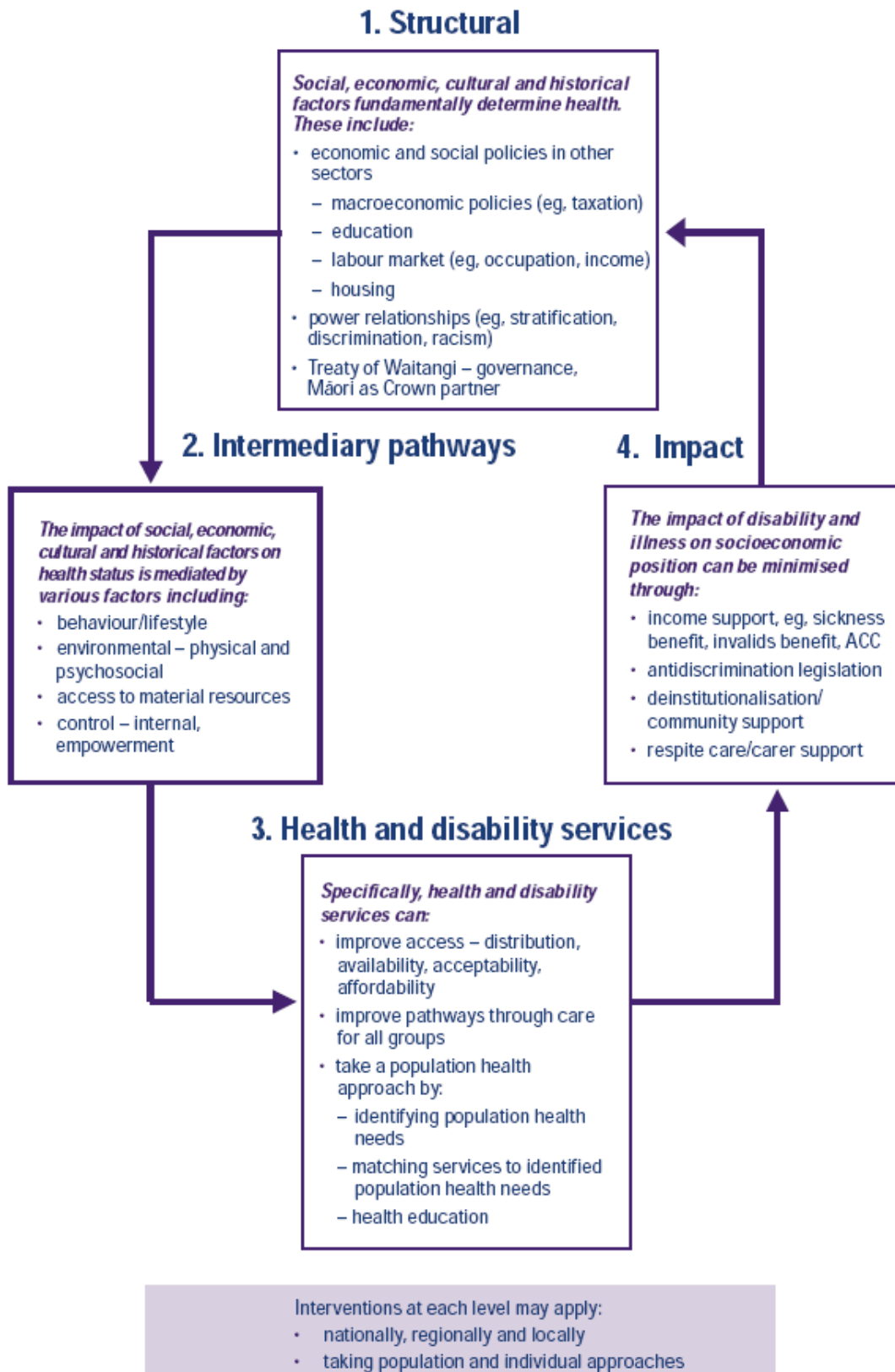
Health inequalities have also become a key focus of health monitoring with an explicit mandate to monitor disparities in district health board and primary health organisation plans. A particular advance in monitoring was the inclusion of a set of questions on experience of racial discrimination in the 2002/2003 New Zealand Health Survey, a household survey which is one of the major data sources to monitor New Zealand health status. The inclusion of the questions on racial discrimination allowed subsequent ground-breaking analyses on the relationship of racial discrimination to health status and new insights into the contribution of discrimination to health inequalities.^{8,31} This questionnaire has since been included in the 2006/2007 New Zealand Health Survey, which will allow trends in racial discrimination and its impact on health to be monitored.

The past decade has thus seen the beginning of a reorientation of the New Zealand health sector at the policy level to take action on health inequalities, driven by public and political concern and supported by robust academic evidence. This has not only been a health focused, with commitment at the highest level of government as noted below from the statement of intent of the Department of Prime Minister and Cabinet:

“Reduce the inequalities that currently divide our society and offer a good future for all by better co-ordination of strategies across sectors and by supporting and strengthening the capacity of Maori and Pacific Island communities. Ensure that all groups in society are able to participate fully and to enjoy the benefits of improved production.”²²

This policy shift has been implemented in a variable manner. However, a range of programmes have been undertaken. One of the most innovative involving multi-sectoral collaboration between the housing and health sectors is described as a case study in the next section.

Figure 1 Reducing Inequalities in Health Framework



Healthy Housing Programme – Public health, public housing, joint action

The Healthy Housing Programme was initiated in Auckland, New Zealand, in December 2000 as an 18 month pilot. The programme was a collaboration between government housing and health agencies aimed at reducing the risk of infectious disease (particularly meningococcal disease) due to overcrowding amongst social housing tenants. Since then, almost 5000 families have had a combined health and housing intervention at a cost of \$60m (mainly capital investment) aimed at improving access to health services and reducing risks to health from their housing environment. The programme is ongoing and has recently received new funding from government to expand to further areas.

The stakeholders in the original programme were New Zealand's main provider of social housing (Housing New Zealand Corporation (HNZ) – a Crown agency which manages housing worth more than \$11 billion, including 66,000 state houses. About 44 percent of state housing is in Auckland.), the health authority for the South Auckland region (South Auckland Health, now Counties Manukau District Health Board (CMDHB)) and the regional public health services provider for the Auckland region (Auckland Regional Public Health Service (ARPHS)). The main catalyst for the programme was the group B meningococcal epidemic in New Zealand which began in 1991. This epidemic resulted in New Zealand having levels of meningococcal disease around ten times higher than other developed countries. Furthermore, there were gross disparities in the incidence of the disease with extremely high rates of disease in young (under 5 years old) Māori and Pacific children in South Auckland.³² Geographic mapping by ARPHS showed concentrations of incidence of disease in social housing areas in the South Auckland region.

With no immediately available vaccine for the epidemic meningococcal strain (although later developed and offered to all New Zealand children from 2004), the initial focus was on the social determinants of the disease. A case-control study showed that during the epidemic, overcrowding was the most important risk factor by some magnitude with an odds ratio of 10.8 for each extra person per room in a home (compared with odds ratios of < 2 for other environmental factors such as tobacco smoke).³³ There was thus a powerful narrative of the nation's most vulnerable children being killed and injured by a disease of poverty, exacerbating inequalities, particularly in housing provided by the state. This narrative was mobilised both for the action that led to the Healthy Housing Programme and also for the subsequent development and rollout of an epidemic strain specific vaccine. The Chief Executive Officer of HNZ was a powerful advocate for the Healthy Housing Programme, voicing the aim that 'no child should die because of the state of their house.' (D.Matheson, personal communication 2002)

Community involvement in this project occurred in a variety of ways. The main district level structures are the district health boards, and these are composed of a majority of community elected people, including Maori members. The NGO sector (civil society) plays an active role, including provision of services that are state funded, as well as policy input. In this initiative the government agencies consulted with community organisations, including NGOs , churches and local government who were active in the area. The concern about Meningococcal disease, which was

one of the entry points of this program was widely shared by government agencies and community alike.

There were few prior models for an intervention like the one planned, so a working group was set up between the three agencies to develop a programme plan for the pilot. Following consultation with community a programme was developed which provided a joint housing and health intervention, capitalising on the strengths of the three organisations involved. The three aims of the programme were agreed upon by the partners as: to reduce crowding levels in HNZ properties; to reduce the risk of meningococcal disease; and to implement intersectoral measures that reduced housing-related disease.

Locations for the programme were chosen by reviewing the avoidable hospitalisation rates associated with crowding-related infectious disease along with the number of HNZ properties in the region, and poverty and general overcrowding rates. Individual houses were chosen in the pilot according to high risk for crowding from HNZ tenant data, but as the programme has progressed, all HNZ properties in the target locations were assessed.

The initial intervention consisted of a visit by a HNZ official and a public health nurse from ARPHS. The starting point of the intervention was an assessment of the needs of the tenants. A joint assessment tool was utilised whereby the HNZ official discussed the housing needs of the family and inspected the housing stock while the public health nurse undertook a comprehensive health assessment of all household members and aimed to increase access to primary health services and knowledge of health promoting practices. Both project members also aimed to identify other social issues. Following this, the HNZ official assessed housing work that was needed and implemented this while the public health nurse arranged any referrals that were necessary to health providers. This plan was reviewed by a clinician from CMDHB also. The public health nurses involved were very experienced and as such were able to contribute a range of practical assistance beyond the narrow health sector. Referrals were thus also made to other social service agencies.

Baseline data collected included data around avoidable hospitalisations, level of crowding (using a crowding ratio) and a meningococcal disease risk ratio to help to prioritise families for housing improvements. Housing improvements included simple maintenance, ventilation and insulation improvements, transfers to larger accommodation and extensions to the existing property. The New Zealand Institute of Architects was consulted to assist with the design of the improvements to maximise the health benefit.

As noted above, the programme is ongoing and has now expanded in size and in coverage, including moving to other areas. Detailed evaluations of the programme have been carried out with the key findings being that the health of HNZ tenants involved improved, crowding was reduced with improvements to the housing stock, there was a 37% reduction in housing related avoidable hospitalisations in programme homes compared to a control group and a cost-benefit analysis suggested a positive benefit to cost ratio of 1.15 for HNZ (who managed the budget for the whole programme). In other words, there was a net financial gain when housing benefits and hospital admissions were considered

without taking into account the economic value of reduced admissions and other non-quantifiable social benefits such as the reported increased wellbeing and community participation among HNZ tenants. Moreover, the programme has been an example of intersectoral action aimed at groups with high health inequalities. Pacific families have comprised 50% of programme participants and Māori families have comprised a quarter.³⁴

Given the relatively small sample, however, it has not been possible to show differences in health incidence for specific infectious disease. This will require a longer timeframe of evaluation but it also underscores the difficulties of providing evidence of the value of programmes aimed at health inequalities. Regardless, the programme is a highly innovative example of how sectors can work together to address health inequalities in a timely manner – and moreover how such action is enhanced by intersectoral collaboration. Despite the particular driver in this case of the meningococcal epidemic, it is unlikely this programme would have proceeded without the convergence and interplay of the different elements identified above.

In summary, these include the inequalities and health determinants focused research, the development of whole of government focus on inequalities, the development in the health sector of specific pro equity health strategies, tools and monitoring, and structural re-design of the health sector to support inequalities focused intersectoral action. Alongside and supportive of this was strong support from the broader community.

The Healthy Housing Programme has now itself encouraged other intersectoral collaboration between the health and housing sectors in other parts of the country, particularly with regard to insulation schemes, some of these efforts are being implemented at a very local level through community level primary health organisations. The spread of this concept has been greatly aided by the realisation that benefits accrue over a short period (months not decades) to both Health and Housing agencies (good return on investment for housing, and reduced admissions for health) as well as the benefits for their communities.

It should be noted that this was not the only response to the Meningococcal disease epidemic. During this time the government developed and delivered a vaccine to the country's 20 years olds, with an initial focus on the south Auckland community where rates of the disease were highest. So in effect, interventions were occurring at all levels, reducing social stratification, reducing specific exposures, decreasing vulnerability, and the provision of health care.

Impact of changing health policy in New Zealand on health inequalities

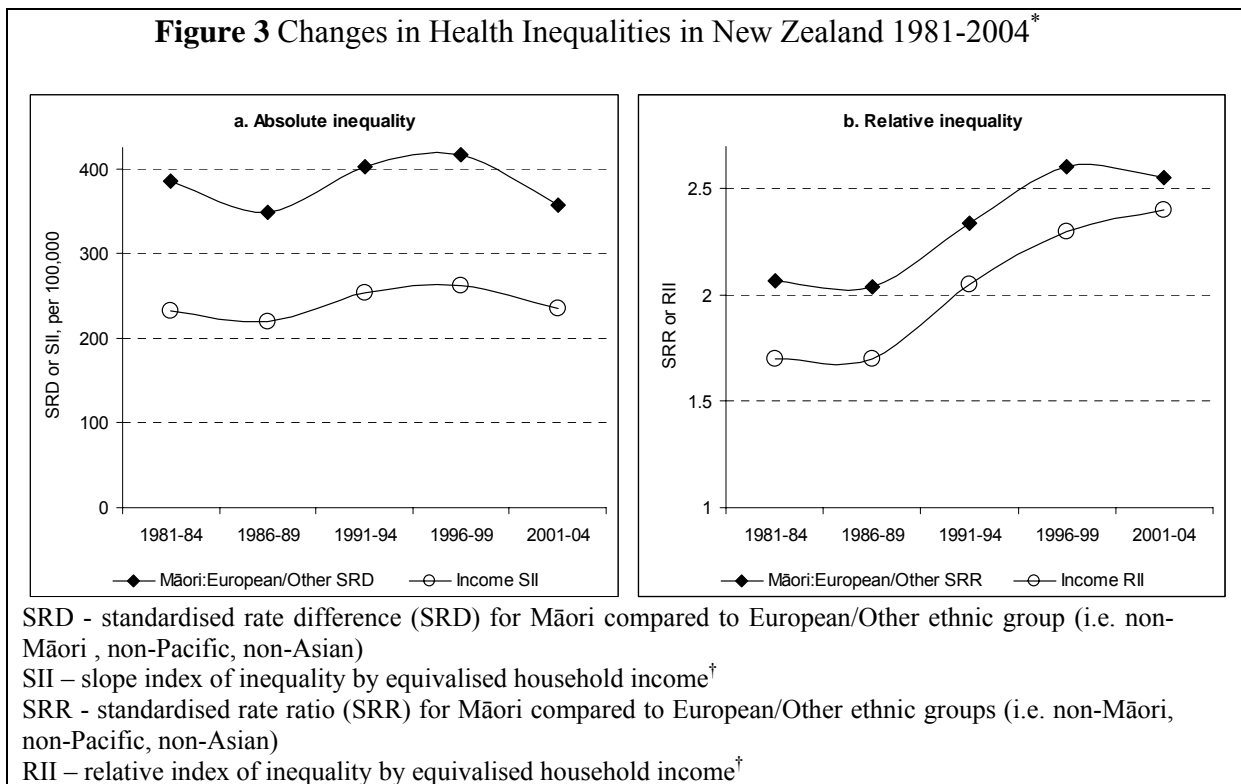
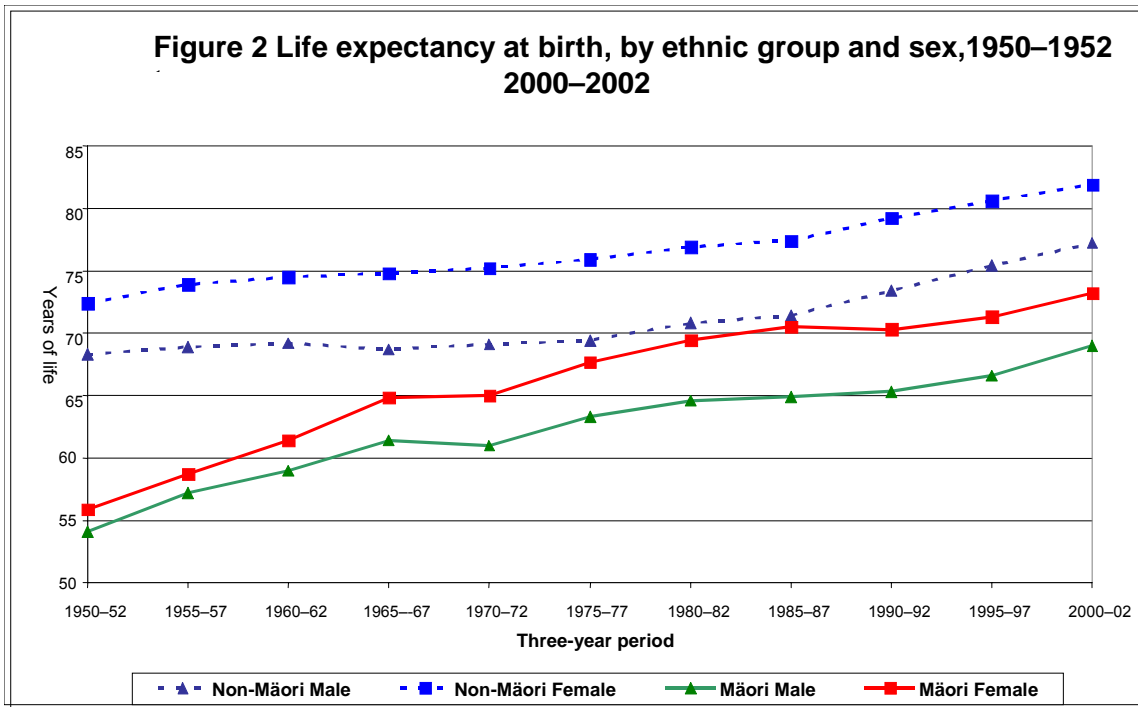
It is notoriously difficult to estimate the impact of specific health policies on health outcome over a short time period. The inability to document impact on infectious disease incidence in the above case study is also seen with much broader health policies and programmes, especially due to the multiple influences on health status. The story of New Zealand's focus on health inequalities is still incomplete and it is too early to conclusively say whether this will lead to a sustained reduction in disparities.

However, there is emerging data which suggests that health inequalities are decreasing in New Zealand according to ethnicity and stabilising according to socio-economic status. Figure 2 below shows that the life expectancy gap between Māori and non-Māori narrowed during the 1950s – 70s, widened during the 1980s and 90s, and may now be narrowing once more.³⁵ Figure 3 below shows trends in absolute and relative inequality in all-cause mortality over the period 1981 to 2004, with ages (1-74 years) and sexes pooled.³⁶

The figures show that both ethnic and socio-economic inequalities in health have followed a similar trajectory. From 1981 to 1986, inequality decreased slightly or remained stable, whether measured on an absolute or relative scale. However, from 1986 to 1999 inequality increased steadily, especially when measured on a relative scale - the increase in relative inequality between ethnic and socio-economic groups was steep and relentless. This period corresponds to the period of major structural and economic reform in New Zealand, offset by a lag of two to three years.

From 1999 to 2004, instead of inequalities continuing to increase further, absolute inequality fell for both ethnic and socio-economic groups, while relative inequality stabilised or fell slightly for Māori vs. European ethnic groups, while continuing to increase (but much less steeply) by equivalised household income.

The apparent turning point in health inequality between 1996-99 and 2001-04 is of great interest. The source of this data, the New Zealand Census Mortality Study, cannot of itself explain the apparent change in trend. However, the pattern is at least consistent with the widening of health inequalities occurring after a very short lag following the increase in social inequality caused by the structural reforms begun in 1984. The observed turnaround coincides (after a similarly short lag) with the changes in government policy described above in the health sector and also in the broader social sector, including increased regulation of the labour and housing markets and increased social assistance. However, it also coincides with improved performance of the New Zealand economy with greatly reduced unemployment rates. As such, it is difficult to attribute the improvement in health inequality to either one of these trends exclusively – both are likely to have contributed to the recent narrowing in both socio-economic and ethnic inequalities in health.



* Standardisation is to the WHO World Population. Incomes are adjusted for CPI movements and equivalised for household size and composition.

[†]SII and RII are regression-based equivalents of the SRD and SRR.

Conclusion

A senior health official recalls being asked by the parliamentary Health Select Committee in 2001, ‘Have you addressed health inequalities yet? If not, why not?’ (D.Matheson, personal communication) - less than two years after the start of substantive policy in New Zealand to address health disparities. This paper describes the experience of New Zealand in reorienting its health and social policy to prioritise reducing health inequalities. Much has been achieved in a very short period and the planning of health interventions and the monitoring of their effects are now highly informed by the need to consider health disparities. However, as has been discussed throughout the paper, this is very much an incomplete narrative. Despite the impressive changes in policy and strategies, implementation remains variable, even given the existence of innovative projects such as the Healthy Housing programme described above.

There is evidence to support the benefits of small programmes, and even to suggest that the overall change in policy direction has contributed to reducing health inequalities in New Zealand. However this evidence is inconclusive. In many ways this reflects one of the major difficulties for social policy which aims to address the social determinants of health – the effects are long-term over multiple programme areas yet the perceived costs of any such policy are immediate.

Sustaining the will to continue with such programmes remains an ongoing challenge for the Ministry of Health and the health sector more generally, as suggested by the quotation from the Health Select Committee above. In New Zealand, the prioritisation of action on health inequalities for Māori was the subject of strong criticism in 2004³⁷ which directly resulted in a review of these programmes by the government to ensure the measures being undertaken were in response to need. In the case of health inequalities, there have been few substantive changes to the focus on ethnic disparities, but the language has changed from an explicit ‘closing the gaps’ commitment and this has caused uncertainty in parts of the sector. However, the impressive body of evidence that has been accumulated to document health inequalities has assisted in maintaining the consistency of health policy in relation to disparities. It is important to note that throughout the above narrative that government has played a central role in facilitating evidence and moving policy forward, in concert with academia and civil society. New Zealand’s experience with this is different from many other countries and this broad consensus improves the chances of sustaining the health inequalities agenda over the long term.

This requires continuing to focus evidence and policy attention on health inequalities and implementing robust evaluation to demonstrate that policies aimed at reducing health inequality are having the desired effect. If such an approach is sustained, New Zealand has chance of substantially reducing inequalities over the decade.

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Appendix I Strategies with Inequality Focus.

New Zealand Health Strategy



New Zealand Health
Strategy

New Zealand Disability Strategy



New Zealand
Disability Strategy

He Korowai Oranga (Maori Health Strategy)



He Korowai Oranga,
Maori Health Strategy

Reducing Inequalities in Health



Reducing Inequalities
in Health

Whanau Ora Health (Impact Assessment)



Whanau Ora Health
Impact Assessment

A Guide to Health Impact Assessment: A Policy Tool for New Zealand



A Guide to Health
Impact Assessment

Relevant Health & Housing Structures



Relevant Health &
Housing Structures

Appendix II Policy Tools for Addressing Health Inequalities

A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health (May 2004)

There is considerable evidence, both internationally and in New Zealand, of significant inequalities in health between socioeconomic groups, ethnic groups, people living in different geographical regions and males and females (Acheson 1998; Howden-Chapman and Tobias 2000). Research indicates that the poorer you are, the worse your health. In some countries with a colonial history, indigenous people have poorer health than others. Reducing inequalities is a priority for government. The New Zealand Health Strategy acknowledges the need to address health inequalities as ‘a major priority requiring ongoing commitment across the sector’ (Minister of Health 2000).

Inequalities in health are unfair and unjust. They are also not natural; they are the result of social and economic policy and practices. Therefore, inequalities in health are avoidable (Woodward and Kawachi 2000).

The following set of questions has been developed to assist you to consider how particular inequalities in health have come about, and where the effective intervention points are to tackle them. They should be used in conjunction with the Ministry of Health’s Intervention Framework (Ministry of Health 2002).

1. What health issue is the policy/programme trying to address?
2. What inequalities exist in this health area?
3. Who is most advantaged and how?
4. How did the inequality occur? (What are the mechanisms by which this inequality was created, is maintained or increased?)
5. What are the determinants of this inequality?
6. How will you address the Treaty of Waitangi in the context of the New Zealand Public Health and Disability Act 2000?
7. Where/how will you intervene to tackle this issue? Use the Ministry of Health Intervention Framework to guide your thinking.
8. How could this intervention affect health inequalities?
9. Who will benefit most?
10. What might the unintended consequences be?
11. What will you do to make sure it does reduce/eliminate inequalities?
12. How will you know if inequalities have been reduced/eliminated?

(Adapted from Bro Taf Authority. 2000. *Planning for Positive Impact: Health inequalities impact assessment tool*. Cardiff: Bro Taf Authority.)

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Source: Te Roopu Rangahau a Erü Pomare., Ministry of Health and Public Health Consultancy. 2003. *A Health Equity Assessment Tool*. Wellington: Public Health Consultancy, Wellington School of Medicine and Health Sciences.

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