

***Keeping up to date* - the 20th edition**

This summary of recent health promotion literature is intended to help:

- increase health promoters' access to the health promotion literature;
- increase health promoters' awareness of some of the current thinking and latest research findings in the field;
- increase health promoters' use of this information in practice.

Keeping Up to Date is produced four times a year. Assistance with accessing articles in journals/periodicals should be available through university, polytech, DHB or local libraries. However if you have difficulty accessing any of the papers, contact the Forum and we can point you in the right direction.

From the Editor

Welcome to our first *Keeping Up to Date* for 2006. This edition focuses on one issue, Health and Social Inequalities. Our contributing writers are **John F Smith and Nicki Jackson**, both of Auckland University of Technology. As their paper shows, there are major and growing inequalities in health status between rich and poor countries and across social groupings within many countries.

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Title Health and Social Inequalities: Issues of Justice and Fairness

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There are major and growing inequalities in health status between rich and poor countries and across social groupings within many countries. Japan has the longest predicted healthy life expectancy, 74.5 years, with Sierra Leone, the shortest, at less than 26 years (WHO, 2002). These starkly dramatic figures are only one of a litany of health and social indicators that could be used to tell similar distressing tales about unequal distribution of health status and life opportunities; for example, infant and maternal mortality, illness rates, nutrition status, early childhood care, income levels, housing standards, and differential access to education, employment and health care services. The consistent compelling message: the poorer you are, the worse your health status is likely to be.

Health status is also distributed unequally within countries. New Zealand research shows health inequalities (or disparities) across income groups, ethnic groups, populations living in different geographic areas (urban vs. rural), and males and females (Ministry of Health, 2002). There are also interactions between these factors. For example, half of the Maori population and a larger proportion of Pacific peoples also live in very deprived neighbourhoods (Tobias & Howden-Chapman, 1999). Socioeconomic status alone does not explain the complexity of health disparities. A burgeoning volume of research has identified a range of social factors (determinants) linked to inequalities in health status (Marmot, 2005). The primary causes of health inequalities in New Zealand are likely to be as a result of uneven distribution of, and access to, income, education, employment, healthcare and housing (Ministry of Health, 2002). Good quality housing can also act as a protection against

(Continued on next page)

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other socio-economic stress factors, such as low income, lack of wealth and unemployment (Howden-Chapman, Crane, Matheson, Viggers, Cunningham, Blakely, et al., 2005).

There is a social gradient effect underlying the distribution of health status. Each socio-economic group tends to experience worse health than the group that is a little better off than it is (Ministry of Health, 2002). Widening income inequality *per se* is bad for national health, whatever the absolute material standards of living within a country (Lee, 2005). Over the 1980s and 1990s, New Zealand experienced the fastest increase in income inequality of any country for which data were available (Hills, 1995).

Relative poverty (measured by the income gap between the poorest and the richest groups) appears to impact more on health status than absolute poverty (measured by minimum income required to survive). This is evident when examining the association between Gross National Product (GNP) and life expectancy. There are countries with quite low GNP (more people in absolute poverty) but higher life expectancies, when compared with some richer countries with larger GNP (and larger relative poverty gap) but with lower life expectancies (Lee, 2005). Increasing income inequality is not only bad for health. It is bad for the economy, bad for people's working lives, and bad for infrastructural development (Smith, 1996), and can breed interpersonal violence and crime (United Nations, 2005).

Addressing the social determinants of health is the fairest and most effective way to improve health for populations and reduce inequalities (WHO, 2006). If we accept that social and economic inequalities drive health disparities then, ethically, we must address those policies and practices that produce and reproduce such social and economic disparities. We must acknowledge that social determinants of health go much wider than the health sector and are sensitively related to social, political and community processes and policy making. Influencing them requires engaging with the processes that produce such policies and practices -the "causes" of the determinants. This requires, at least, multi-level participation in, and promotion of, democratic processes for policy formation, implementation and review at

central, local government and community organisation level.

One pragmatic vehicle for putting potential health effects before policy-makers is the Health Impact Assessment Guide (Public Health Advisory Committee (PHAC), 2005). Designed largely, but not exclusively, for use by policy makers outside the health sector, it provides a lens for considering potential health impacts of policy especially on health inequalities. It aims to elevate review of the health implications of new policies to the same status as economic implications, which are routinely analysed before policies are finalised. It is one approach to living out the Ottawa Charter's calls for intersectoral action and macro-level promotion of healthy public policy.

The Health Promotion movement has always been associated with achieving equity and reducing inequalities. Its guiding principles from the Alma Ata Declaration and the Ottawa Charter are a rich and eloquent articulation of values like fairness, social justice, social inclusion, community participation, rights to both health and access to the resources to sustain it. However, at the program level even well-intentioned health promotion campaigns, undertaken with a utilitarian focus to achieve the greatest good for the greatest number, can actually widen the inequality gap. Apparent overall improvements in health behaviours may, in fact, mask increasing differences between socio-economic groups (Macintyre, 2003; Victora, Vaughan, Barros, Silva & Tomasi, 2000). For example, evidence of increasing relative inequalities in New Zealand has been demonstrated in relation to smoking after a period of comprehensive tobacco control. Although mainstream anti-smoking interventions resulted in decreased average tobacco use, there were increasing inequalities in smoking, particularly in disadvantaged (low income, low education) groups, and Maori and Pacific peoples (Hill, Blakely, Fawcett, & Howden-Chapman, 2005). It is likely that new interventions first reached those who were already better off (higher socio-economic status): the "inverse equity hypothesis" (Victora et al, 2000). This hypothesis suggests that only when the wealthy have improved to the point where public health interventions are unlikely to make more progress, will the disadvantaged

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begin to catch up and the inequity gap begin to narrow (Victora et al, 2000). Thus, only over time will inequality gaps be narrowed, unless specific policies and programs address disadvantaged groups' needs.

At the program and community level, narrowing of the inequality gap requires removing social and cultural barriers to health interventions and community development processes. It is also imperative that health promotion initiatives be designed and "screened" for potential health outcome differences across groups (eg., ethnic groups, SES levels etc).

At the planning stage we need to consider potential differential health effects of our activities; what inequalities already exist in this area, who is most advantaged and how, how might our interventions effect this imbalance; how will we measure the outcomes to detect any inequality effects, and so on? The Health Equity Assessment Tool or "equity lens" (Ministry of Health, 2004) is a critically useful framework for this purpose. It provides a matrix of 12 questions to guide programme development to ensure likely effects on health inequalities are to the fore in programme planning. Developing a body of effective ways for reducing health inequalities in New Zealand is essential for health promotion practitioners and our communities.

Recent natural disasters have also signposted the inequalities that exist in the world today. The catastrophes of the Indian Ocean tsunami and the New Orleans hurricanes have focused our attention on the susceptibility of the poor and vulnerable populations (Marmot, 2005). In the words of New York Times' columnist David Brooks, storms like hurricane Katrina "wash away the surface of society, the settled way things have been done. They expose the underlying power structures, the injustices, the patterns of corruption and the unacknowledged inequalities" (Brooks, 2005).

Social determinants, including poverty as listed above, are on the agenda of many international organisations whose focus is to reduce inequalities. Tackling poverty throughout the world, and reducing childhood mortality (strongly associated with deprivation) is essential to the United Nations Millennium Development

Goals. In March 2005, the World Health Organisation established the Commission on Social Determinants of Health. The Commission is charged with recommending interventions and policies to improve health and narrow health inequalities through action on social determinants.

The need to focus on reducing health inequalities is compelling. Within the health promotion movement, we need multi-level engagement from the macro-level where we might influence policy and social and community systems—the "causes of the causes", through to programme level to ensure our efforts work towards reducing disparity and not inadvertently perpetuating them. The Health Impact Assessment Guide, the Health Equity Assessment Tool and the recently developed Guide to Developing Public Health Programmes (Ministry of Health, 2006) are three practical ways of approaching this task. Understanding the production and maintenance of social and health inequalities and attempting to redress these disparities are undoubtedly challenging and complex tasks. Not to strive to do so, is unfair, unethical and undermines our very own health promotion values of social justice, social inclusion, and the pursuit of the highest health status and quality of lives for our communities.

Source

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Recommended websites

Ministry of Health <http://www.moh.govt.nz/inequalities> (contains literature on inequalities, the Intervention Framework and Health Equity Assessment tool)

Ministry of Health - *A guide to developing public health programmes: A generic programme logic model* <http://www.moh.govt.nz/moh.nsf/by+unid/3980073CB3F0231ECC257146001881DD?Open>

WHO Commission on Social Determinants http://www.who.int/social_determinants/en/

Department of Health, United Kingdom <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthInequalities/fs/en>

Health Inequalities Research Collaboration, Australia