The Health of People and Communities

A Way Forward: Public policy and the economic determinants of health

Report to the Minister of Health
From the Public Health Advisory Committee

October 2004
Ma te huruhuru te manu ka rere
Feathers enable the bird to fly

“The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social.”
Geoffrey Rose (The Strategy of Preventive Medicine. 1992.)
The Health of People and Communities

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A report to the Minister of Health by the Public Health Advisory Committee
Te Rōpū Tohutohu i te Hauora Tūmatanui

October 2004
The Public Health Advisory Committee (PHAC) is a sub-committee of the National Advisory Committee on Health and Disability (the National Health Committee). It provides independent advice to the Minister of Health on public health issues, including the factors underlying the health of people and communities.

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COMMITTEE FOREWORD

This report is concerned with the relationship between socioeconomic status and health. It shows that the chances of enjoying good health and a long life continue to reflect differences in socioeconomic position and ethnicity. And it focuses on the role that public policy can play in reducing inequalities in health.

Inequality in health outcomes is considerable. New Zealand men on low incomes have twice the risk of premature death as men on high incomes. Being Māori further increases the risk of death across all socioeconomic categories. The association of social position and health is as powerful for children as for adults. The risk of death for children in low income households is about twice that for children in high income households.

Dramatic difference between those in the highest and those in the lowest income households is only part of the picture. It is not just poverty that is associated with poorer health and a shorter life. Each step down the distribution of household income is associated with an increased risk of premature death. Those in the second decile of household income have a greater chance of premature death than those in the top decile – and so on down to the lowest decile. Health inequalities affect all New Zealanders, not just the poorest.

Tackling health inequalities cannot be the task of the health system alone. Ensuring that all New Zealanders are reached by effective prevention programmes and have access to health care are key roles of the health system. But health inequalities are also powerfully affected by the broader pattern of public policy. Breaking cycles of disadvantage offers government one important lever for change. Interventions that get children and young people off the pathway of poor education and poor chances of employment are not only good in themselves but also diminish health risk. Equally important are policies that deal directly with the broader structure of inequality. Making sure that people not only have the work skills and access to childcare that enable them to take up employment, but also that there are enough jobs providing sufficient income is one important role for policy. Another is access to sufficient income support for those unable to work. Good quality, affordable housing, and life long opportunities for education are important for everyone.

The recommendations in this report focus less on the broad spectrum of policy than on first steps. They are of four kinds. First, reducing poverty, especially child poverty, will make a real difference to the health risks that low income households face. The government is already committed to this goal. We argue for the importance of setting measurable objectives and reporting on progress toward them. Second, we recommend a ‘whole of government’ responsibility for co-ordinating and monitoring policy for reducing health inequalities. This gives government the ability to utilise its full range of policy levers – not just those in health – to improve health outcomes. Third, our recommendations focus on making transparent the changing relationships of socioeconomic status and ethnicity to health outcomes and on tracing the health effects of central and local government policies. Only then will we know what difference particular policies make and how effectively we are reducing health inequalities. Finally, our recommendations focus on the need for research to identify more effective policy interventions and to better understand the causal paths linking socioeconomic status, ethnicity and health. Knowing what to do will require discovery and social innovation.

Geoff Fougere
(Chair, Public Health Advisory Committee)
EXECUTIVE SUMMARY AND RECOMMENDATIONS

Chapter 1 – Introduction
- Wide disparities in health exist among people in New Zealand. The challenge is to improve the health of all to the same level as those who have the best health, without distinction for ethnicity, social or economic position.
- This report builds on a 1998 National Health Committee report and focuses on more recent evidence of the effect of economic policies on the socioeconomic determinants of health and the links with health outcomes.
- The strongest influences on people’s health come from factors outside the health system. They include the social, cultural, physical and economic environments in which people live.

Chapter 2 – Perspectives on health
- Historically, concepts of health differ between Western and indigenous paradigms. However, in some contexts, Western views of health may be moving closer towards the broader indigenous concepts of health.
- Throughout this report, health is defined as including physical, mental, emotional, family/whānau, community and spiritual wellbeing.
- Socioeconomic and other determinants influence health not just at one point in time, but throughout life. Adverse socioeconomic circumstances during childhood are more potent predictors of health in later life, than subsequent circumstances and lifestyle choices.

Chapter 3 – Economic context
- Economic growth brings benefits such as increased incomes and material quality of life, but is not sufficient on its own to reduce poverty for marginalised groups.
- Globalisation brings opportunities and constraints on national governments. Government policy can mediate between international pressures and the lives of its citizens.

Chapter 4 – Macroeconomic policy in New Zealand
- Economic approaches influence social policy as well as having the potential to directly affect the health of citizens.
- Taxation, such as tobacco tax, can be used for direct public health benefit.
- Labour market changes and changes in benefits in the late 1980s and early 1990s had a significant and adverse effect on low income households, and in particular, on children and Māori.

1 National Health Committee. 1998. Social, Cultural and Economic Determinants of Health
Family income assistance has been, until Budget 2004 announcements, very tightly targeted in New Zealand, compared with other developed countries.

The move away from state involvement in the housing sector was paralleled by an increase in rents and a drop in home ownership.

Chapter 5 – Māori health and economic factors

A legacy of past economic policies is disparity between Māori and non-Māori socioeconomic status. This disparity has contributed to health disparities.

During the past 20 years, Māori life expectancy improved little but has recently shown signs of improvement. However, premature death and disease in the Māori population remain at unacceptably high levels.

The Treaty of Waitangi underpins understandings between Māori and the Crown and the way in which pathways for improving Māori health through economic policy and development can be negotiated.

The Māori economy is small but significant. To be successful, Māori economic development must be consistent with the views and aspirations of Māori.

Chapter 6 – Association between socioeconomic factors and health

The socioeconomic determinants of health impact differentially across the population creating health inequalities.

As income decreases, rates of poor health increase.

Poverty is multidimensional and people experience its effects throughout their lives.

Children from poor families have higher rates of illness, injury and death than others.

Unemployment and low levels of education are related to poor health outcomes.

Death rates decline with each step up in occupational class.

High housing costs contribute to considerable hardship for low-income families and have a strong influence on their health. People on low incomes are most likely to live in poor and/or crowded housing.

The deprivation level of the small geographical areas in which people live is a predictor of variation in health status.

Cost tends to be a barrier to accessing health care for people on low incomes. There is a differential access to health care between ethnic groups, which is independent of cost.

Chapter 7 – Explanations for socioeconomic differences in health

Evidence for the effect of socioeconomic factors on health is accumulating and becoming more convincing, but less is known about the reasons for this effect.
Explanations include social capital/income inequality, and material resources. Evidence is strongest for the effect of people’s material circumstances on health.

Large differences in mortality exist between ethnic groups even after allowing for differences in income.

Explanations for the differences in health status between Māori and non-Māori include macroeconomic and structural factors, as well as differences in risk factors for disease, and differences in access to appropriate health care services.

Chapter 8 – Policy interventions

The evidence for a direct causal relationship between specific government policy and health outcomes is generally ambiguous, but there are indicators that suggest that socioeconomic position and resulting health outcomes are modifiable by policy.

Policy interventions to address disparities in health are more likely to be successful if they address the socioeconomic health gradient and employ a range of strategies with a mix of universal and targeted approaches.

Intersectoral collaboration is required to address the fundamental determinants of ill-health, with policies routinely assessed for their potential impact on health (health impact assessment).

Chapter 9 – Priorities for action

The Public Health Advisory Committee recommends to the Minister of Health that the New Zealand Government:

1. Adopts the goal of improving the health of all, without distinction for ethnicity, social or economic position, to the same level as those who have the best health.

The Public Health Advisory Committee recommends that the following actions be taken toward the realisation of this goal (the goal):

2. Develop an official poverty measure by July 2005, set measurable objectives for the reduction of poverty and monitor progress toward meeting these objectives.

3. Aim to reduce child poverty by at least 30 percent by 2007, and make continuing improvements until child poverty is eliminated in New Zealand.

4. Assign to an appropriate body ‘whole of Government’ responsibility for coordinating policies and monitoring effects on health inequalities.

5. Develop the capacity for health impact assessment to ensure consideration of the effects on health of central and local government policy during the process of policy formation.

6. Require the routine reporting of data on socioeconomic status, ethnicity and health at the national and district health board levels. This should include analyses by socioeconomic status within ethnic groups.

7. Fund research for identifying policy interventions that reduce health inequalities and to better understand the causal paths linking socioeconomic status, ethnicity and health.
1 INTRODUCTION

1.1 The challenge to improve health

Wide disparities in health exist among people in New Zealand. Those with the best health can expect to live long and healthy lives, but many people experience significant and avoidable ill-health. Although this ill-health is distributed across the whole population, it is disproportionately borne by specific groups such as Māori, people with low incomes and Pacific peoples.

Those in the best health have a longer life expectancy showing that it is possible to achieve this level of good health. The challenge for New Zealand is to improve the health of all to the same level as those who have the best health.

There are sound economic and social reasons for seeking to improve health and well-being. Recent research has estimated that if the health status of all New Zealanders was at the level of those with the best health in the country, then approximately 4,800 deaths could be avoided. Improved health status would also reduce work absences, potentially bringing higher productivity and overall economic gains for the country.

1.2 This report

This Public Health Advisory Committee (PHAC) report to the Minister of Health builds on the 1998 National Health Committee report on social, cultural and economic determinants of health and focuses on new evidence that has arisen since 1998. This 2004 report is based on three information strands: a literature review and Māori analysis, interviews with government and non-government agencies, and a workshop and hui that looked at possible policy responses to identified public health problems.

The socioeconomic determinants of health and wellbeing discussed in this report include education, employment, occupation, income, housing and area of residence, and the public policies that shape them. The report makes links between these determinants, the health gradient across the New Zealand population, and the effects on specific population groups. It describes the New Zealand economic context and the effects that economic policies have on the socioeconomic determinants of health. The document takes a ‘whole of government’ approach, to reflect the influence other sector policies have on health outcomes.

This report uses a conceptual model of the determinants of health that recognises the effect of structural conditions on factors that affect the health of individuals, families and communities (see fig 1).

“Of all the forms of inequality, inequalities in health are the most inhumane of all.”

Martin Luther King Jr

ii The review and Māori analysis can be accessed on http://www.nhc.govt.nz/phac_pubs.html
This model represents the different levels of influences on health, ranging from those at an individual level, such as biological age, sex and genetic characteristics, through the influences that come from the communities in which people live and work, to the structural conditions that are largely driven by factors outside the control of individuals (socioeconomic determinants of health). Although the individual factors in the central circle of the model have a strong influence on people’s health, these factors are largely unmodifiable by policy, public health or medical interventions. It is important to make this distinction in order to identify determinants of health that are the most responsive to interventions. This report focuses its attention on the wider socioeconomic determinants of health (towards the outer edges of the circle) that have the potential to be modified by government policy.

1.3 Tackling the determinants of health

In order to improve the state of public health, it is necessary to understand the major influences on public health and on health inequalities. Throughout history, people’s health and life expectancy have differed according to their social status, ethnicity and the material conditions in which they live. Less is known about the mechanisms and pathways that relate people’s material conditions to their health status, although the body of knowledge is growing.

“The greatest advances in the health of the people (in the nineteenth century) were probably the indirect results of better housing and working conditions, the general availability of soap, of linen for underclothing, of glass for windows, and the humanitarian concerns for higher living standards.”

Rene Jules Dubos (1901–1982)
These material conditions and the social and political structures that create them are known as the **wider determinants of health**, ‘upstream’ or **macro-level** factors. They include international influences, government policy, and the social, cultural, economic, and physical environmental contexts in which people live their lives.

There is strong evidence that these determinants (particularly social and economic factors) significantly affect health and health inequalities. This evidence goes against popular opinion that says that the health care system and lifestyle choices are the main influences on health. People’s lifestyle choices do affect their health but their choices are strongly influenced by socioeconomic circumstances. For example, diet choices will be largely determined by the amount of money people have to spend on food. Health services have had an impact on the health of populations, particularly in the last two generations, but still do not have the potential to improve health to the same degree as improving housing, employment or income.

In describing the associations between economic and social factors and health, the PHAC acknowledges that there are a number of limitations in the methods used to measure these associations. The most important measurement issues are listed in Appendix One.

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**Summary**

- Wide disparities in health exist among people in New Zealand. The challenge is to improve the health of all to the same level as those who have the best health, without distinction for ethnicity, social or economic position

- This report builds on a 1998 National Health Committee report and focuses on more recent evidence of the effect of economic policies on the socioeconomic determinants of health and the links with health outcomes

- The strongest influences on people’s health come from factors outside the health system. They include the social, cultural, physical and economic environments in which people live.

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iii National Health Committee. 1998. Social, Cultural and Economic Determinants of Health
2 PERSPECTIVES ON HEALTH

Concepts of health vary across time, groups and contexts. How health is defined and viewed impacts on perceptions about the links between economic policy, socioeconomic determinants and health outcomes.

2.1 Concepts of health and wellbeing

Concepts of health and wellbeing vary widely in western and indigenous worldviews. Indigenous concepts of health are more likely to be based on belief systems that do not separate people from their social, cultural and physical environments; that see their collective and individual health and wellbeing depends on a balance between all of these factors. A strong thread running through all indigenous peoples’ concepts of health is the importance of aspects that span generations incorporating physical, mental, emotional and spiritual health. This approach links strongly with the lifecourse perspective that has recently emerged in generic public health approaches.

Although western origins of the concepts of health were likely to have been broad and based on concepts of wellbeing, (Old English hael meaning whole), the concept of health narrowed during the 18th century with the increasing dominance of medicine. This led to health often being defined in a narrow bio-medical model, referring only to illness and disease states. The term “wellbeing” is used primarily by other social sectors and equates closely with broad definitions of health.

Throughout this report, the PHAC defines health broadly as including physical, mental, emotional, family/whânau, community and spiritual wellbeing.

2.2 Lifecourse perspective

As well as there being a diversity of perspectives about health, the impacts of socioeconomic factors vary at different stages of people’s lives. Adverse socioeconomic circumstances during childhood tend to be more potent predictors of health in later life than adult circumstances and lifestyle choices.

The lifecourse perspective provides a framework for conceptualising how diverse influences from before birth, through childhood and adolescence, and during adult years, can influence health. This perspective is important in establishing causal pathways from child poverty to adult health outcomes.

Socioeconomic factors that have been shown to have an influence throughout the lifecourse include income, employment status (including parental occupation), welfare policies, housing and education (including maternal education). The lifecourse perspective provides a way of considering how these factors inter-relate over time. For example, low levels of social support have a greater negative effect on the psychological health of people living in poverty than those on higher incomes.

Longitudinal studies are helpful in identifying lifecourse effects. Results from the Dunedin Multidisciplinary Health and Development Study indicate that low socioeconomic status in childhood has long-lasting negative influences on adult health, irrespective of what a person’s socioeconomic status is at birth or in their adult years.
Evidence suggests that there are ‘critical periods’ when exposure to deprivation has a disproportionate effect on health in later life. Before birth, childhood, and adolescence all appear to be critical periods. Time lags often occur between the event that leads to poor health and the onset of ill-health or early death.

Lifecourse effects also result from accumulation of disadvantages and/or advantages. Poor circumstances at one life stage can be mitigated by better circumstances earlier or later in life. Advantages and disadvantages can accumulate across generations, perpetuating socioeconomic disparities between population groups.

The lifecourse perspective is a useful way to trace the cumulative effects of health determinants over time, including between generations, and to highlight the effect of critical periods. But economic impacts on health can be sudden and acute. For example, the move in Eastern European countries from centralised to market economies led to a sudden decrease in life expectancy and changes to the sex ratios for cardiovascular disease.11

**Summary**

- Historically, concepts of health differ between Western and indigenous paradigms. However, in some contexts, Western views of health may be moving closer towards the broader indigenous concepts of health.

- Throughout this report, health is defined as including physical, mental, emotional, family/whānau, community and spiritual wellbeing.

- Socioeconomic and other determinants influence health not just at one point in time, but throughout life. Adverse socioeconomic circumstances during childhood are more potent predictors of health in later life, than subsequent circumstances and lifestyle choices.
3 ECONOMIC CONTEXT

This chapter provides a summary of the economic context in which policies have affected the socioeconomic determinants of health.

3.1 The economy and life expectancy

Much has been written about the links between a nation’s economic prosperity and life expectancy. There is a connection between a country’s income and the longevity of its people. Countries with a high per capita gross national product (GNP) have a correspondingly high overall life expectancy. The converse is also true, with many developing countries having a poor economy and low life expectancy.

However, there are some exceptions to this connection. Some countries and states with very low GNP per head, such as China, Sri Lanka and the state of Kerala in India, have enjoyed much higher life expectancies than other much richer countries, such as Brazil, Namibia, Gabon and South Africa.

The success of these countries in maintaining a healthy population with relatively high life expectancies has been attributed to the investment in public services, such as health care and education, which helps to alleviate the effect of low incomes on the health of the population.12

3.2 Economic growth and inequalities

Economic growth is essential to improve the living standards of the population and to generate sufficient resources to alleviate poverty. In spite of this, economic growth is not sufficient on its own to reduce poverty for marginalised groups in developed countries such as New Zealand.13

Evidence points to the need for effective mechanisms to ensure that the benefits of economic growth also reach those most in need. The implementation of such mechanisms depends on policy initiatives, given that the ‘trickle down’ effect is not sufficient for increased resources to reach deprived people. Policies to ensure benefit across the population work through the labour market to ensure minimum wages, training opportunities and permanent jobs, and through social policy to ensure adequate income assistance to prevent deprivation.14 However, socioeconomic gradients in health have complex causes and their elimination may depend on more than the redistribution of resources, as highlighted by the persistence of health inequalities in egalitarian societies such as in Scandinavia.13

Income inequality in New Zealand rose significantly during the recession of the late 1980s but did not fall during the subsequent economic expansion of the mid 1990s. It is likely that the income inequalities were driven by societal and structural changes that were not subsequently reversed.15 The most significant contributing factor to the increase in income inequalities seems to have been the increases in income inequality among the employed, which reflect the widening income differentials by occupation, education and hours of work.14

3.3 Economic growth and sustainability

Economic growth brings benefits such as increased incomes and material quality of life, but can also be associated with negative impacts on the social and physical environment.
It is a challenge to governments to encourage economic growth without reducing the ability of the environment to keep providing resources at the same level into the future, and without having an adverse effect on sections of the population. Economic decisions must be made in conjunction with social, cultural and environmental decisions to ensure sustainability.

The New Zealand Government’s stated economic goal is to grow an “inclusive, innovative economy for the benefit of all, that aims to improve the skills of all, close the gaps for Māori and Pacific people in health, education, employment and housing, and protect and enhance the environment. The concept of sustainable economic development is central to the achievement of these goals.” It is therefore important that the health sector works to ensure that health outcomes are closely linked with sustainable development policy-making. Health Impact Assessment is a policy tool that should be promoted as one of a range of tools that can contribute to a sustainable development approach across government.

3.4 The global context

The rate of change in the flow of information, goods, capital and people has accelerated in recent decades. Although the integration of the global economy has a long history, recent rapid improvements in telecommunications, the dismantling of trade barriers, the rise of global financial markets and the expansion of the political and economic power of multinational corporations, have all contributed to greater interconnection between countries and their economic and social systems.

This increased international economic and social connection brings with it new opportunities and new constraints in which national policy-making occurs. The way that governments respond to the buffeting and uncertainties of international markets will affect economic growth and socioeconomic conditions. The public health sector internationally is concerned about trends in globalisation that could affect health, such as:

- increasing control by multinational corporations of basic utilities such as food and drinking water supplies
- health care systems being developed for commercial gain rather than public good
- exploitation of natural resources
- spread of disease vectors such as exotic mosquitoes.

However, globalisation could also bring new opportunities for economic growth and poverty reduction. It is important that government policy takes advantage of the opportunities while ensuring that buffers are put in place to mediate between potentially negative international pressures and the lives of its people.

Summary

- Economic growth brings benefits such as increased incomes and material quality of life, but is not sufficient on its own to reduce poverty for marginalised groups
- Globalisation brings opportunities and constraints on governments. Government policy can mediate between international pressures and the lives of its citizens.
4 MACROECONOMIC POLICY IN NEW ZEALAND

The focus of this report is on how economic policy influences the socioeconomic determinants of health. This section examines four specific areas of recent economic policy in New Zealand that impact directly upon socioeconomic status, with particular emphasis on policy changes in recent decades.

4.1 Taxation

In the last 15 years, income taxes in New Zealand have been reduced substantially, particularly for the high-income brackets. The rationale was to promote economic growth and encourage foreign investment. In 1986 the top tax rate was reduced from 66 percent to 48 percent and a Goods and Services Tax (GST) introduced with no exemptions. The top tax rate was further reduced to 33 percent in 1988 but raised again to 39 percent in 1999. Targeted assistance was introduced to help ‘at risk’ families. The threshold of $9,500 for the lowest tax rate of 15 percent has not been adjusted despite the 60 percent inflation since 1986. New Zealand has one of the lowest top tax rates in the OECD countries.

The combination of these tax cuts, along with benefit cuts, contributed to the inequalities that developed during the late 1980s and early 1990s.

The Treasury has argued that to raise the level of low incomes in a sustainable way, it is necessary to improve education and job opportunities at the lower end of the income distribution, rather than redistribute taxes through benefits. This is the concept of ‘social investment’ – investing in social benefits – providing support in times of hardship. Lower taxation rates for people on low incomes, and family tax credits can also be used for increasing incomes for poor households.

4.1.1 Taxation for direct health benefit

The evidence is strong that increasing the price of harmful products such as tobacco and alcohol decreases their consumption and therefore contributes to favourable health outcomes. Public health advocates recommend that tobacco and alcohol taxes continue to rise at levels above inflation, and that other measures should also be put in place to give incentives for people to give up or cut down their intake. This is an example of using desirable policy mixes to gain the most health benefit. There have been calls by the public health sector for such taxes to include taxes on fatty foods or the advertising of foods that do not meet nutritional guidelines, with the goal of reducing obesity. There have also been calls for alcohol taxes to more effectively target young men’s alcohol abuse.

4.2 Labour Markets

The labour market pattern in the 1990s showed an increase in unemployment and ‘work poor’ households, a slight increase in ‘work rich’ households where all adults were working, and a decrease in ‘mixed work’ households where one adult was supporting another. The employment policy of the time was primarily concerned with reducing competition between wage rates and benefit levels, encouraging a return to work by reducing income support, and reducing trade union influences on wage levels.
The changes had a marked impact on children and on Māori. In 1996, nearly 36 percent of ‘work-poor’ households included children, compared to an OECD average of 18.7 percent.\(^{18}\) The reforms adversely affected Māori by restructuring many of the industries that employed them.\(^{19}\) Unemployment rates for Māori reached a high of 29 percent in 1992 but have since improved significantly.

Even with similar levels of education, and adjusting for other factors (e.g age) non-Māori are advantaged in the labour market. Labour market discrimination against Māori has been reported in the areas of both wages and occupational status.\(^{19,20}\)

The current government’s Employment Strategy aims to reduce welfare dependency and poverty by promoting a sustainable ‘employment rich’ economy, removing barriers to employment growth and developing a skilled workforce. Particular emphasis is being put on Māori and Pacific employment and capacity building initiatives.

Recent data indicates that the labour market has moved in the right direction, with June quarter 2004 unemployment rates of 4.0 percent\(^{iv}\) being considerably lower than the OECD average of 7.1 percent. Māori and Pacific unemployment has dropped significantly since 1992 (25.4 percent for Māori and 28 percent for Pacific people) although is still disproportionately high (10.2 percent for Māori in 2003 and 7.7 percent for Pacific people). There is also a large disparity in employment opportunities between regions, with unemployment being disproportionately high in Northland (8 percent) and some other rural areas of New Zealand.

The direct impacts of employment on health are discussed in section 6.3.

### 4.3 Social assistance

The current New Zealand benefit structure was established by the Social Security Act 1938, with the aim of providing for those ‘in need’.\(^{22}\) The vision was of a classless society where full employment and the welfare system would close the gaps between the rich and poor, and provide state funded care ‘from the cradle to the grave’.\(^{23}\)

Along with economic changes that began in the late 1980s, significant changes were made to the welfare state. Universal policies were considered extravagant; social security was more narrowly ‘targeted’ at those in most need; and the self-reliance of individuals and families was promoted.\(^{22}\)

The radical retrenchment of the welfare state from 1990–91 is now associated with increased poverty and a subsequent drop in health status among some groups in society.\(^{23,24}\) The restructuring included benefit cuts and a move away from universal benefit provision to income-based targeting for those most in need. These changes were in conjunction with other economic reforms such as the increased costs of education, housing and health care. The changes were introduced without research into their possible impact on beneficiaries, children, Māori or other groups. The negative effects this policy mix had on people who were already disadvantaged are now known.\(^{23,24}\) The voluntary sector stepped in to provide much of the additional assistance families needed, for example, meeting increased demands on food banks.

An initiative called ‘Strengthening Families’ was introduced to reduce family dysfunction and identify family problems at an early stage. The intervention included cross-sectoral work to improve interagency coordination and is still in place. However, family assistance has suffered from political prominence given to the superannuation needs of older people. In 1998, state superannuation was again made universal in spite of the tight targeting of support for families with children.24

Compared internationally, family support income assistance has been very tightly targeted in New Zealand, until Budget 2004 when targeting was broadened. Family support is not inflation adjusted, even though most income support payments, including New Zealand Superannuation, are inflation adjusted.16 Family support was last adjusted in 1998 and has since declined in real terms by 5.5 percent. The government has announced its intention to “significantly increase direct income support and incentives to move from welfare benefits into paid employment” in Budget 2004.25

A recent trend in New Zealand is the increase in the number of people on Sickness and Invalids Benefits, which reflects international experience. Sickness and disability affects people’s ability to work, which then impacts on the economy as well as on the individual’s health. Many countries are struggling to reverse this trend.

Adjustments to taxation and welfare benefit systems can alleviate the effects of poverty on health. However, these adjustments do not address the root causes of poverty such as unemployment, low educational attainment and high accommodation costs. Welfare policies need to be more than just the provision of benefits, they need to create routes to employment, and to reduce barriers created by cost.

4.4 Housing policy

Throughout most of the 20th century successive governments in New Zealand have played an important role in supporting individuals and families to purchase their own homes. The state became a central agency in both the provision of rental housing and the financing of house purchase. This, and the ability to capitalise on family benefit, contributed to the high rate of home ownership in New Zealand, which in 1992 was 74 percent.26 By 2001 home ownership had fallen to below 68 percent.27

In 1991 there was a shift away from housing as a major part of state welfare provision, towards a market-based approach. The government introduced market based rents for state housing, with the Accommodation Supplement for housing assistance to tenants in public and private sector housing and homeowners where it was needed. This resulted in a sharp increase in rents, a factor the Child Poverty Action Group has identified as a key driver of poverty.28

Rental increases during this time greatly exceeded inflation. In 1988, one in eight households spent more than 30 percent of their income on accommodation. Ten years later this had increased to one in four households, with one in three children living below the poverty threshold.29 Families reduced their costs by increasing the number of people per house or using temporary accommodation such as sheds, garages and caravans.

\* The poverty threshold was taken to be below 60 percent of the median equivalent disposable household income after adjusting for housing costs.
In 2000, income related rents for state tenants were reintroduced, setting the base proportion at 25 percent of household income. The Accommodation Supplement continues to be available for low-income homeowners and tenants in the private sector.

During the 1990s, home ownership levels dropped for the first time since the 1940s, attributable to dramatically increased house prices. There was also an increase in the transience of households, likely to be a reflection of the increased number of families renting.29

The government is currently consulting on a draft housing strategy, which has the vision for all New Zealanders to have access to “affordable, sustainable, good quality housing appropriate to their needs”.28

<table>
<thead>
<tr>
<th>Summary</th>
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<tbody>
<tr>
<td>♦ Economic approaches influence social policy as well as having the potential to directly affect the health of citizens</td>
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<tr>
<td>♦ Taxation, such as tobacco tax, can be used for direct public health benefit</td>
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<tr>
<td>♦ Labour market policy changes in the late 1980s and early 1990s had a significant and adverse effect on low income households, in particular on children and Māori</td>
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<tr>
<td>♦ Family income assistance has been, until Budget 2004 announcements, very tightly targeted in New Zealand, compared with other developed countries</td>
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<td>♦ The move away from state involvement in the housing sector was paralleled by an increase in rents and a drop in home ownership.</td>
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5 MĀORI HEALTH AND ECONOMIC FACTORS

5.1 Māori health – a needs based issue

Economic factors are one of the forces that shape Māori health. Economic policy in New Zealand has often been developed without taking into account the impacts on Māori health, cultural values or identity. One of the legacies of such policies has been disparities between Māori and non-Māori in socioeconomic status and in health status. These disparities remain wide although there are some recent indications that the differences in life expectancy may be reducing. However, premature death and disease in the Māori population is still at unacceptably high levels.

There was a period of rapid gain in Māori life expectancy for the three decades following World War II. However, the last two decades of the 20th century saw disparities between Māori and non-Māori life expectancy increasing. During this time, non-Māori life expectancy at birth increased at the fastest rate since World War II. By contrast Māori life expectancy improved little and the gap between Māori and non-Māori life expectancy widened from six or seven years, to about nine years. (see Figure 2).

![Figure 2: Māori and non-Māori life expectancy by gender, 1950–2000.](image)


The latest life expectancy estimates from Statistics New Zealand suggest that Māori life expectancy has started to improve and the difference between Māori and non-Māori life expectancy narrowed from 9.1 years in 1995–7 to 8.5 years in 2000–2002. Lower non-Māori death rates at ages 45–79 account for about three quarters of these differences.

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vi “Sole Māori” relates to a census definition covering the census choice of ‘Māori’ as their only ethnicity

vii Data from Statistics New Zealand website: [www.stats.govt.nz](http://www.stats.govt.nz)
Health inequalities between Māori and non-Māori reflect the unequal distribution of the economic, social, environmental and political determinants of health, although ethnicity appears to have an additional independent effect.

Figures 3 and 4 represent the striking difference in distribution of Māori and non-Māori populations across the socioeconomic gradient. Decile 1 represents the most advantaged group and decile 10 represents the most disadvantaged group. It is clear that Māori are over-represented in the lower socioeconomic groups.

In order to address health disparities, it is important to review how resources that impact on health become distributed unevenly between the Māori and non-Māori populations.

5.2 Māori and the Crown

Acknowledgement of the relationship between Māori and the Crown under the Treaty of Waitangi is an underlying principle of the New Zealand Health Strategy. This principle recognises that successive governments have identified the Treaty of Waitangi as the founding document of New Zealand and have been committed to fulfilling its obligations as a Treaty partner. The Treaty of Waitangi underpins understandings between Māori and the Crown, and the way in which pathways for improving Māori health through economic policy and economic development can be negotiated. Within the framework of Māori development, emphasis is placed on the Treaty as a forward-looking document, rather than as primarily relating to settling historical grievances. The Treaty of Waitangi relationship is one of the more significant determinants of Māori development, relevant to social and economic policies.

The Waitangi Tribunal was established in 1975, in order to address Māori claims about matters inconsistent with the Treaty. As at 3 October 2000, 870 claims had been registered with the Waitangi Tribunal.

Te Ohu Kai Moana (Treaty of Waitangi Fisheries Commission) was allocated fishing quota and cash under the Māori Fisheries Act 1989 and the Treaty of Waitangi Fisheries Settlement Act 1992. This allocation was to assist Māori to purchase fishing companies. Te Ohu Kai Moana currently owns approximately 37 percent of the tradable fishing quota in New Zealand. There are other acts for other settlements. The Waikato Raupatu Claims Settlement Act 1995 and the Ngāi Tahu Claims Settlement Act 1998 are two other examples. Long-term economic benefits for Māori are expected to result from these and other settlements.

5.3 The Māori economy

A Māori economy has been defined as collectively owned land trusts and incorporations, Māori owned businesses and the property owned by Māori households. This definition broadly suggests that Māori have collectively designed and implemented an economic plan that produces a stable and strong economic base for all Māori. It does not capture the entrepreneurial nature of Māori individuals who may collaborate in business ventures, offer employment to Māori and provide competitive services and products in the global market. The wages and salaries earned by Māori workers outside the Māori economy contribute to the wider New Zealand economy.

Initiatives that have and are currently being negotiated through tribal councils and the Crown for the purpose of progressing tribal economies may more accurately describe a collective Māori economy. Māori economic development incorporates the strengthening of Māori culture. Concepts of Māori economic development are integrated with social and cultural development and are therefore significant for Māori health. Alignment of

“the Muriwhenua claims are about .... Government programmes instituted to relieve Māori of virtually the whole of their land, with little thought being given to their future wellbeing or to their economic development in a new economy.”

Waitangi Tribunal 1997
Māori economic development with Māori views and Māori aspirations will ensure that progress is not being analysed within frameworks that would disadvantage Māori people.34

Māori-owned commercial assets produce more export revenue ($650 million) than New Zealand’s overall wine, wool, kiwifruit or fisheries industries. Māori households and businesses pay $2.4 billion in taxes and Māori households also earn $4.3 billion in wages and salaries each year, a substantial contribution to the total taxable income from wages and salaries.33

Imposed perspectives accompanying aid packages from multi-nationals often undermine the economies of developing countries. Māori economic development could suffer a similar fate if a narrow developmental model, conflicting with Māori worldviews, was the signpost of the direction ahead.34 Desired outcomes need to be identified for Māori economic development, as do reliable instruments to measure them.

**Summary**

♦ A legacy of past economic policies is disparity between Māori and non-Māori socioeconomic status. This disparity has contributed to health disparities

♦ During the last 20 years, Māori life expectancy improved little but has recently shown signs of improvement. However premature death and disease in the Māori population remain at unacceptably high levels

♦ The Treaty of Waitangi underpins understandings between Māori and the Crown and the way in which pathways for improving Māori health through economic policy and development can be negotiated

♦ The Māori economy is small but significant. To be successful, Māori economic development must be consistent with the views and aspirations of Māori.
6. ASSOCIATION BETWEEN SOCIO-ECONOMIC FACTORS AND HEALTH

The general conclusions in the National Health Committee’s 1988 report on the social, cultural and economic determinants of health have continued to be supported by new evidence published since then. This chapter summarises the evidence for the association between socioeconomic factors and health. More details can be found in the literature review and Māori analysis commissioned by the PHAC to inform this project.3,4

6.1 Differential impact on sectors of the population

The determinants of health impact differentially on sectors of the population, resulting in health inequalities. These health disparities are potentially preventable and therefore considered to be unacceptable.35

There are at least two important mechanisms that have the potential to produce differential impact. People from less advantaged backgrounds are likely to be exposed to more health hazards and risk factors than other groups. They are also likely to be more susceptible to a given level of hazard or risk because of the cumulative effect of multiple disadvantage.35

Some families are more resilient than others, protecting them from the worst effects of deprivation. The protective mechanisms at work are not fully understood, but it is thought that strong social connections and whānau support are likely to protect against some of the adverse effects of material disadvantage.

It is important to remember that although some groups are disproportionately represented in poor health statistics, people living in deprived circumstances with consequent poor health, represent a wide cross section of society. It is also important to acknowledge that there are not just two groups representing well-off healthy people and those who are deprived with poor health, but there is a gradient across society. This health gradient roughly reflects socioeconomic status with health status improving at each improved level of social and economic circumstance.

6.2 Income

Income is a strong predictor of health status and is represented by a gradient.3 As income decreases, rates of poor health including mortality, morbidity, and self-reported health status, increase.36 In New Zealand the association between household income and mortality is very strong. New Zealand men on a low income have twice the risk of premature death than men on high incomes.37
Figure 5: Age and ethnicity adjusted odds ratios of all-cause mortality by equivalised household income for 25–44 and 45–64 year olds, males and females. (Bars are 95 percent confidence intervals).


Figure 5 shows strong gradients across income levels of deaths from all causes, with those in the highest income groups having the lowest death rates.

Some evidence also suggests that health returns diminish after income increases beyond a certain point.\textsuperscript{38,39} Most often, reduced household income leads to poorer health, but also, household wealth and income are often reduced after a household member becomes ill.\textsuperscript{40} While the income gradient exists across all groups in New Zealand society, some populations are disproportionately represented in low income groups, eg, Māori and Pacific households, single parent families and households on welfare benefits. Those who are users of mental health services are also over-represented among lower socioeconomic groups, because of the lower earning power of people with a mental illness. A male service user in New Zealand has a life expectancy of 61.7 years, compared with 65 years for a Māori male and 75.7 years for a pākehā male.\textsuperscript{41}

A 2002 study by the Council of Christian Social Services found that sole mothers and their children were high users of food banks. The study found that these sole parent families were under extreme pressure from debt, high housing costs and increased cost of living. It found that people “did not have the ability to buy the amount and type of food necessary for a healthy life.”\textsuperscript{42}

The Māori population has a younger age structure than the general population. This coupled with lower levels of education and a less skilled workforce results in a lower median income for Māori families. For example, Māori workers earn on average 80.5 percent of the hourly rate earned by pākehā workers.\textsuperscript{43} In addition, Māori in all income groups have worse health than non-Māori in the same income groups, indicating that there are factors operating over and above the effects of income on health. Recent work
on the New Zealand Census Mortality Study by Blakely et al, has shown that high-income Māori death rates were 2.25 times higher than high-income Europeans. More needs to be known about the pathways that result in Māori having higher death rates than non-Māori at every income level. (See also section 7.3).

Pacific populations also have a young age structure. Pacific people and families tend to have lower incomes than the total New Zealand population, which contribute to their poorer health status. (See also section 6.6.1). An additional effect on income for Pacific families is regular gift giving. This is a result of the strong cultural and kinship ties and obligations among Pacific peoples, including transfer of money from New Zealand family members to relatives in their islands of origin. In a recent study of Pacific families, 60 percent of mothers reported that their partner regularly gifted money to the church or to family members, which made the financial situation in the family difficult.

Disabled people in New Zealand are more likely to live in low-income households and have lower personal incomes than their non-disabled peers. Many working-aged disabled people live on low incomes for long periods of time. (Income and employment issues for disabled people are discussed in 6.3.1.)

Income is only one factor in determining people’s material standard of living. The term poverty is often used to describe living in ‘deprived’ conditions. The next section looks at how poverty affects health status.

6.2.1 Poverty

Poverty is multi-dimensional and its effects are felt across the lifecourse of individuals, communities and generations. Public health was founded on the evidence of the relationship between poverty and health in the 19th century, when public health actions led to significant improvements in the health of the most vulnerable. It is now clear that poverty can be alleviated by investment in education, income support systems, employment opportunities, and safe living and working conditions. Actions that are most likely to be successful at alleviating poverty will also be multidimensional and will consist of a range of policy interventions.

Research also suggests that the level of income over a long term is more significant for health than over a short-term. Short-term spells of poverty can, however, have a negative effect on health if they occur at an early stage in a child’s life. (See also section 6.2.2 below). People who are persistently poor have the worst health outcomes compared to those who experience poverty only occasionally or not at all.

Definitions of poverty tend to focus on people’s relative living standard compared with the living standard of a particular society. The New Zealand Poverty Measurement Project (NZPMP) has adopted the definition:

“a lack of access to sufficient economic and social resources that would allow a minimum adequate standard of living and participation in that society.”

There is no official poverty measure in New Zealand and therefore no consistency. This PHAC report refers to a poverty threshold of income below 60 percent of the median...
equivalent, disposable household income (as described by the NZPMP). It is important that New Zealand adopts a poverty measure to enable consistency across sectors and to make research results comparable.

The NZPMP found that during the 1990s, Māori were twice as likely to be in poverty as pākehā/Europeans and Pacific people were more than three times as likely to be in poverty. However, looking at total numbers, over half those in poverty are pākehā. A 2001 report by Easton, addressed some common perceptions about who in New Zealand were most affected by poverty. The report estimated that over 80 percent of people in poverty are children and their parents, with over half of these in two parent families; over half of those in poverty are in paid employment; and over half of those in poverty are pākehā. These statements are based on absolute numbers. In relative terms, one parent families, households on welfare benefits, Māori, ethnic minorities and those who are chronically ill are more likely to be living in poverty.

Disabled people’s organisations have challenged the existing definitions of poverty, which focus on lack of the basic necessities of life (absolute poverty) or not being able to live in accordance with the customs and values of society (relative poverty), in favour of the emerging rights-based approach that highlights the way in which civil, political and social rights are undermined by poverty. This approach is compatible with the social model of disability, on which the New Zealand Disability Strategy is based, and the wish of disabled people to have their rights as ‘ordinary’ citizens recognised. In this context poverty can be seen as one manifestation of a disabling society.

6.2.2 Poverty and child health

According to the United Nations Convention on the Rights of the Child (1990), every child is entitled to an adequate standard of living for their “physical, mental, spiritual, moral and social development”. Although New Zealand ratified this convention in 1993, poverty among children has increased over the past fifteen years.

It is estimated that almost one in three children in New Zealand live in poverty. In 2001, just over 29 percent of children were in families considered to be in poverty. This was almost twice the proportion recorded in 1988. Children, particularly younger children, are much more likely than adults to live in low-income households. Poverty is not confined to households on income support. Over half of the children who live in poverty are in households where there is at least one employed parent.

Poverty is structured differentially along ethnic lines, for instance 49 percent of Māori children and 42 percent of Pacific children live in families in economic hardship. In comparison, 21 percent of pākehā children live in financially disadvantaged circumstances. Pākehā children from low income families tend to be in poverty for less time than Māori children.

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viii using a threshold of income below 60 percent of 1998 median equivalent net-of-housing-cost family income
Socioeconomic factors play a significant part in affecting children’s health in New Zealand. Children from poorer families have higher rates of illness, injury and death than other children.\textsuperscript{2}

Research suggests that even brief experiences of poverty can have adverse impacts if occurring at a young age, and children who live in extreme poverty over time are more likely to have the poorest health.\textsuperscript{45} Poverty influences housing conditions in which children live. Families on low incomes and facing high housing costs are more likely to live in sub-standard, unhealthy or crowded housing. Poverty can also seriously limit children’s opportunities to access education and health care and to participate in family and cultural activities.\textsuperscript{24}

Children from poor families have higher rates of illness, injury and death than other children.\textsuperscript{2} A linked census-mortality study conducted in New Zealand found that for 0–14 year olds, the death rate in the lowest socioeconomic categories of household income was approximately double that of the highest categories.\textsuperscript{53}

Economic hardship also produces differential effects on the health of children living in poverty. For instance, a comparison of SIDS (Sudden Infant Death Syndrome) rates within the most economically deprived communities showed that Māori had a SIDS rate that was six times higher than that of pākehā.\textsuperscript{54}

A recent report compared the child benefit packages across 22 industrialised countries. New Zealand was ranked near the bottom of almost all the measures and was described as having a negative child benefit package because high housing costs and charges for services cancel out the value of tax benefits for children.\textsuperscript{55} A University of Otago longitudinal study has shown that the health status of adults is conditioned by their socioeconomic experiences in childhood and the authors advised “protecting children against the effects of socioeconomic adversity could reduce the burden of disease experienced by adults.”\textsuperscript{56} Quite apart from effects of child poverty on adult health status, children have a right to be protected from the effects of poverty.

### 6.2.3 Living standards

Income is only a rough measure of living standards. People living on the same income can have quite different standards of living. For people on low incomes, factors such as savings or debts, length of time receiving a low income, family assets, financial commitments and access to non-monetary resources all influence the standard of living they can achieve.

The Ministry of Social Development has developed the ELSI scale (Economic Living Standards Index), which consolidates information about different aspects about living standards into a single score.\textsuperscript{57}

Analysis of data from 2000 using the ELSI scale indicates that children’s living standard scores are disproportionately in the lower part of the range, but that not all groups of children are at risk of a lower living standard. This risk particularly exists for children in sole-parent families who receive income from income-tested benefits. These children are much more likely than other children to experience constraints that may adversely affect their health, education and general development. Affordability controls visits to the doctor and dentist, and the purchase of glasses.\textsuperscript{57}
The 2000 data also show significant ethnic differences in the distribution of ELSI scores. They indicate that Māori have lower living standards than the population as a whole and that substantial disparities still exist when the youthful age structure of the Māori population is taken into account. In addition, a much higher proportion of Māori children are at the lower end of the living standard scale. In terms of total numbers however, more pākehā live in households with lowest living standards.

Pacific people are also disproportionately represented in the lower parts of the scale and have the highest proportion of any ethnic group in the segments of the scale that indicate the lowest standards of living.\textsuperscript{57}

For low-income families, levels of debt can be a significant determinant of living standards. A study commissioned by The New Zealand Council of Christian Social Services found an unequal distribution of debt, with more severe impacts on Māori, Pacific, women and families with children. A key factor contributing to debt is the high financial cost of raising children. The research showed that debt impacted on the physical and mental health of low-income families.\textsuperscript{58}

\textbf{6.2.4 Current trends in New Zealand income (from The Social Report 2004)}

\begin{itemize}
  \item The difference in income between top income earners and bottom income earners has been rising since 1988, with the most rapid increase occurring between 1988 and 1994. Most of the increase has been due to a larger overall rise in the top 20 percent of income earners. Incomes of the bottom 20 percent have remained constant over the whole period.
  \item In the year to June 2001, 22.6 percent of the population were considered to be in poverty. The proportion of the population with low incomes increased sharply in the early 1990s, reaching a peak in the mid 1990s (27 percent). The proportion of low income people is currently higher than it was in 1988 when it was 13 percent.
  \item Higher than average likelihood of being below the 60 percent line in income exists for sole parent families, families that rely on income-tested benefits as their main source of income, families with any Māori adult, Pacific adult or adults belonging to other ethnic groups, those living in rented dwellings and families with dependent children.
  \item In 2000, 20 percent of the population had living standards in the bottom three levels of the ELSI scale.\textsuperscript{ix}
\end{itemize}

\textbf{6.3 Employment}

Participation in secure paid employment is the main influence on the ability to have and maintain an adequate income, which in turn impacts on health status. The UK Acheson report\textsuperscript{59} considered that:

\begin{quote}
  "unemployment is an important determinant of inequalities in the health of adults of working age in Britain, with people lower down the social scale being hardest hit."
\end{quote}

Longitudinal studies provide good evidence that unemployment has a direct causal relationship with health outcomes.\textsuperscript{3}

\textsuperscript{ix} See section 6.2.3 for a description of the ELSI scale.
Unemployment or threatened job loss can have an effect on both physical and mental health, although the effect appears to be greatest for mental health. The costs of long term unemployment are high and include negative effects on an unemployed person to the point that their self-confidence and motivation to seek work is severely impaired.60

Clear linkages have been drawn between suicide rates and unemployment. A New Zealand study using census mortality data, showed that unemployment was associated with a two to threefold elevated risk of death by suicide, although there may have been some confounding by mental illness.37

Figure 6 shows the rates of suicide among young adults during the past two decades. In the early 1980s the labour force participation rates were higher among Māori than non-Māori in the early 1980s and at that time the suicide rates were lower among Māori than non-Māori. Māori rates of youth suicide have accelerated during the past two decades to the point where Māori rates were twice those of non-Māori by 1996–1999. This rise parallels the fact that Māori youth (aged 15–19) are the most likely of all Māori and non-Māori age groups to be unemployed.

A feature of employment patterns over the past 15 years has been an increase in part time and casual work. Such work is characterised by a lack of security, increased exposure to health and safety risks, less control over working hours, and little opportunity for training. A recent New Zealand study based on census data, concluded that:

“the part time employed had an increased odds of mortality compared to the full time employed for each sex by age group except for 25–44 year old females”, 61

Where job losses are widespread in particular communities, whole communities can experience adverse effects on mental health and general wellbeing. This happened in New Zealand in the 1980s when large places of employment closed down in small communities, for example, freezing works and manufacturing industries. The economic impact that the economic restructuring and job losses in the 1980s and early 1990s had on Pacific people is clearly seen in the employment data. (See section 6.6.1 for more details.)
Recent research by Caritas Aotearoa suggests that children are particularly vulnerable in the labour market. This study of children in Catholic primary and secondary schools found that around 40 percent of 10–17 year olds are working, with students from low decile schools more likely to be supplementing family income. The survey responses highlighted several areas of concern, including lack of supervision, work accidents, use of heavy machinery and a high number of children aged under 16 working after 10pm. Low wages were also highlighted, for instance some children worked for less than $2 an hour. Caritas concluded that a higher level of protection is needed for children who work in New Zealand.62

The relationship between employment status and health is complicated by the fact that ill-health is also a cause of people leaving the labour market, with a consequent drop in income. In this situation, the relationship arrow between socioeconomic factors and health is in the opposite direction (reverse causation).

6.3.1 Disabled people, income, employment and health

Throughout developed countries, disabled people are over-represented among poor people. This is true for all groups of disabled people, including people with physical and sensory impairments, people with an intellectual disability and people who have mental health problems.64

The New Zealand Disability Strategy points out that individuals have ‘impairments’ rather than ‘disabilities’. These may be physical, sensory, neurological, psychiatric, intellectual or other impairments. The strategy defines ‘disability’ as:

“the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have” 63

In other words, society is built in a way that assumes that everyone can see signs, read directions, understand instructions and have stable moods, when the reality is that many people with impairments may not be able to do some of these things. This creates barriers which can exclude people with impairments from many facets of society and restrict their access to employment, income, education and housing.

It is important not to equate disability with ill-health. While some disabled people have health conditions for which they need ongoing and frequent access to health services, many do not require ongoing medical care or to access health services to any greater extent than other people in New Zealand.

International data shows that disabled people are twice as likely as non-disabled people to be unemployed,64 which is consistent with the information gathered by the 2001 disability survey in New Zealand.6 x Disabled people tend to be vulnerable in the employment market. Not only is it more difficult for disabled people to get work than for their non-disabled peers, but the work they do tends to be insecure and poorly paid.64 For instance, they are more likely to lose their jobs when economic conditions are tight.65 Globalisation of the labour market and greater competitive pressures mean that many employers are reluctant to employ disabled people.

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*x Calculations using this data suggest that 55 percent of disabled adults aged 15 and over were not in the workforce, compared with just under 25 percent of non-disabled adults. (Statistics New Zealand 2002)
Full-time and continuous employment is not a reality for some people who have long-term disabilities. The National Health Committee identified a group of adults with an intellectual disability who are able to work more than 15 hours a week but are not able to work sufficient hours to earn a viable wage. Also, as a UK study found, there are significant patterns of intermittent disability among working-age disabled people, particularly among those with mental health conditions.

As well as having lower and less secure incomes, many disabled people have additional living costs that result from living with impairments. These can include additional transport costs, medications or special foods, accessing modified equipment and clothing costs. These costs tend to rise with severity of disability and be higher for people living alone.

For disabled people, low or intermittent incomes can mean having to choose between essential items such as food and medications. As paying rent takes up such a significant portion of their income, disabled people tend to live in poor-quality housing, which in turn negatively affects their health. Difficulties with cost or transport can make it difficult to access health care services, which in turn impacts on health status.

6.3.2 Current trends in New Zealand employment (based on The Social Report 2004 and Statistics New Zealand)

- The New Zealand unemployment rate has halved in the years since 1991–1992 and is now significantly less than other comparable countries (4 percent in the year 2003). Twenty seven percent of these have been unemployed longer than six months and one percent longer than five years.

- There are substantial ethnic differences in unemployment rates. In 2003, 10.2 percent of Māori were unemployed, 7.7 percent of Pacific people and 3.5 percent of pākehā. (Given that there is a strong relationship between unemployment and poor mental health, this means that Māori and Pacific people may be more vulnerable to the mental illness associated with unemployment).

- Unemployment is greater in the regions than in the cities, with the highest unemployment in Northland (8 percent in the year 2003).

- There has been an increase in part time and casual employment, and short term contracts in recent times in New Zealand. Over 100,000 people with part time work would prefer to be working full-time.

- Hours of work give information on work-life balance, which may affect health. In 2002, 21 percent of people reported working 50 hours a week or more. This proportion has remained static since an increase in the late 1980s – early 1990s. Employed men are more likely to work long hours than women. The increase in long working hours has been more pronounced in older workers.

- Recently released government data shows that youth unemployment has fallen dramatically, as shown by the 60 percent fall since 1999, in 18 to 24 year olds collecting the unemployment benefit.
**6.4 Occupation**

Occupation is one factor by which people can be grouped into ‘social classes’. People who have low or unskilled occupations have significantly higher death rates than those of the professional classes, and in general mortality rates decline with every step up in occupational class.\(^{71,72}\)

*Figure 7: Age-standardised mortality ratios by Elley Irving occupational class, among 15–64 year old New Zealand males during 1975–77, 1985–87 and by NZSEI occupational class during 1995–97*

Figure 7 shows gradients in mortality across occupational classes, where Class 6 represents unskilled manual workers and Class 1 represents professionals.

These social class inequalities are most pronounced in preventable deaths.\(^{71}\) Studies based on occupational class may also reflect the effect of marginal employment on health.

Mental health and oral health problems, accidental deaths, poisonings and violence, and a number of chronic diseases are more prevalent in people from the unskilled occupational classes.\(^{73}\) Health risk factors including smoking prevalence, alcohol use, body mass index, and sexual behaviour, are also adversely associated with occupational class.\(^{74}\)

Results from the Dunedin Multidisciplinary Health and Development Study show that the social gradient in health is determined during childhood and low socioeconomic circumstances in childhood have a continuing negative impact on health in adulthood.\(^{10}\) The study has shown a graded association with parental occupational class during childhood, for most measures of physical and dental health.\(^{10}\) This lifecourse effect applies regardless of level of the person’s health at birth and socioeconomic circumstances as an adult.\(^{10}\)

The Māori workforce tends to be less skilled, and has less work experience than the non-Māori workforce. As a result it is less adaptable to changes in the demands of the labour market. The over-representation of Māori in manual occupations is a further contributor to lower health status.
Historically, Pacific workers have also been over-represented in less skilled manual jobs in secondary industries and under-represented in more skilled and higher status jobs. This is a result of the patterns that were established during the 1960s and 1970s when Pacific peoples were encouraged to migrate to New Zealand to fill vacancies in expanding secondary industries during a period of full employment. This occupational distribution means that Pacific people tend to have lower incomes than the total New Zealand population, which has implications for their health status. There is greater social mobility and diversity of occupation among younger Pacific people. (See section 6.6.1 for discussion on Pacific people, employment and housing.)

In addition to serving as a surrogate measure of socioeconomic status, occupation is important in itself because occupational exposures are major causes of injury and disease in New Zealand. Approximately 100 workers die each year from workplace injuries, and the toll of deaths from occupational disease is much higher still. About 300 workers each year die from occupational cancer and similar numbers die from occupationally-caused heart disease and from other causes such as respiratory disease.

A study of work-related fatal injury during 1985–94 reported a higher relative risk of death for Māori compared with non-Māori male workers aged 15–84 years. This was highest for Māori men aged over 50 years with the relative risk of death being 2.5 to 3 times higher than that of non-Māori. Although the higher concentration of Māori workers in more dangerous forms of employment means the work-related fatal injury rate would be higher among Māori, there is evidence to suggest that Māori shoulder a larger percentage of the risks than their fellow workers.

While the focus of discussions of socioeconomic factors and health tends to be on the hazards of unemployment and the beneficial effects of paid employment, it is also important to emphasise that paid employment is frequently hazardous and unhealthy, and that these hazards are almost entirely borne by manual workers. Thus, an improvement of working conditions, particularly with regards to occupational health and safety, should be an essential part of any strategy to reduce socioeconomic differences in health.

6.5 Education

There is strong and well documented evidence for the association between levels of education and health status. Well-educated people have better health than less well educated people and, generally, people with the worst health status have low education levels. There is a health gradient that operates across all educational levels.

Literacy level and educational attainment are strong indicators of educational attainment. Low education and literacy levels are strongly related to poverty, malnutrition, ill-health and high infant mortality. A strong relationship exists between lifestyle behaviours that have a negative effect on health eg, smoking, alcohol abuse, lack of exercise and unhealthy eating, and low levels of education.

Most formal education takes place early in life and can potentially modify socioeconomic and health prospects in later life. The median educational performance of New Zealand children ranks among the top of developed countries. However, compared with other countries, New Zealand has a higher proportion of children at the tail end who are performing poorly.
A 2003 review of New Zealand and international literature, found that the consequences to youth (15–19 years) of non-participation in school or work included worse employment opportunities, lower earnings, greater welfare dependence, greater risk of homelessness and limited housing options, higher involvement in crime, worse mental health, and higher rates of teenage pregnancy. Low educational status contributes to cycles of disadvantage. This affects not only the economic standard of living people are able to enjoy, but also their security and ability to make choices about their lives. Participation in high quality early childhood education can narrow the achievement gap between children from low-income families and more advantaged children.

In summary, although New Zealand performs well internationally in overall educational measures, there are large disparities in educational achievement that are reflected also in employment opportunities, income, housing and health status.

### 6.5.1 Current trends in New Zealand education (from The Social Report 2004)

- Participation in early childhood education is high in New Zealand, but Māori and Pacific children are less likely to have attended pre-school than European or Asian children (In 2003 97.4 percent European children, 92.4 percent Asian children, 88.4 percent Māori and 83.4 percent Pacific attended pre-school).

- In 2002, 63 percent of school leavers left school with at least sixth form certificate. This proportion has changed little since an increase in the late 1980s. Girls were more likely than boys to leave with sixth form certificate or higher (68 percent girls, 59 percent boys).

- Māori were less likely than other ethnic groups to leave with a qualification (39 percent Māori, 54 percent Pacific in 2002 compared with 68 percent European and 84 percent of Asian students).

- School leavers from schools in the most disadvantaged communities were less likely to attain higher school qualifications (in 2002, 45 percent in deciles 1 to 3 schools, 60 percent in deciles 4 to 7 schools and 77 percent in deciles 8 to 10 schools).

- A 1996 literacy survey showed that only two other countries had average prose literacy scores significantly higher than New Zealand’s. However, New Zealand has not done well in improving the educational attainment of its lowest achievers, a disproportionately high number of whom are Māori or Pacific people.

### 6.6 Housing

Housing costs are a key determinant of poverty, a factor that is strongly associated with poor health. Housing costs are people’s budgeting priority so if the proportion of their income spent on housing is high, they have less to spend on other basic necessities of life. High rents affect the affordability of good food, fuel for the winter, and access to leisure pursuits. All of these have a flow-on effect on health.

“The connection between health and the dwellings of the population is one of the most important that exists.”

Florence Nightingale 1820–1910
Many aspects of housing affect health. The physical quality of housing, household crowding, cold and dampness, the frequency of moving house, and the nature of tenure (i.e. rental/ownership), are all associated with health. Housing conditions in childhood affect an individual’s health throughout their life. Adults who live in good housing circumstances were found in one study to be more likely to be ill if they had experienced adverse housing conditions earlier in life. This same study concluded, “the impact of housing deprivation would appear to be the same order of magnitude as addressing the issue of smoking.”

Independent associations have been documented between housing conditions and household health, although there is a paucity of evidence for the association between housing and population health.

Household crowding is associated with a higher prevalence of infectious diseases and is a major independent risk factor for infectious disease morbidity among children. Housing quality is also linked to children’s emotional health.

Housing quality and the level of home ownership decline with social class. Those who own their own homes are more likely to have better health than those in temporary and rental accommodation.

There is also a growing body of evidence coming from a New Zealand study on the effect of housing interventions on health. Early results of this work have shown that adults report their health and their children’s health significantly improved after housing insulation. They also report having significantly fewer days off work and that children have fewer days off school. A cost benefit analysis of retrofit insulation (health and energy savings) estimated the tangible benefit as $3,640 per dwelling compared with the cost of installing insulation of $1,800. The analysis showed that saving one hospitalisation recovers the cost of the insulation. The results are pointing strongly to the potential for housing interventions to form a cornerstone of social and health policy.

Due to higher housing costs close to the city, many Māori and Pacific households are confined to the edges of cities with potentially longer travel times and higher travel costs to their place of work. Māori households in main urban areas were twice as likely to spend 25 percent or more of their household income on rent compared to Māori in rural areas. There has been some evidence of a small number of Māori returning to small rural areas in recent years. This is thought to be the result of higher costs of living associated with urban living.

Higher housing costs in metropolitan regions explain higher levels of overcrowding as households on lower incomes seek to manage these higher housing costs. An analysis of crowding in New Zealand households has shown that in 2001 13.5 percent of Māori households experienced crowding and only three percent of European households.

6.6.1 Pacific people, employment, housing and health

Since the large-scale migrations of the 1960s and 1970s, Pacific peoples have become well established within New Zealand society. They have, however, faced a number of challenges due to higher housing costs close to the city, limited access to jobs, and inequities in housing and health policies. The Pacific community has experienced a unique set of barriers and has shown resilience in adapting to these challenges. Further research and policy interventions are needed to support the health and well-being of Pacific peoples in New Zealand.
economic difficulties that have impacted on their health status. As their skills have not always been suited to the demands of the New Zealand market, they have been over-represented among the unemployed, lower skilled workers and low-income earners. The economic restructuring of the late 1980s and early 1990s had a disproportionate effect on Pacific people, many of whom worked in industries and occupations that bore the brunt of job losses.75

Between 1986 and 1991 the employment rate for Pacific people fell from 62 percent to 43 percent (compared with a drop from 61 to 54 percent for the total population). As economic conditions have stabilised and new employment opportunities have emerged, Pacific employment has risen (55 percent in 2001), but has not returned to its pre-1992 level. The age group which experienced the biggest decline in employment between 1986 and 2001 was men in their fifties.75

The effects of this period of high unemployment can be seen in poor housing conditions and the presence of poverty-related health conditions, such as meningococcal disease.

The health status of Pacific people is relatively poor in comparison with the total population. Pacific people have clearly identifiable health problems, many of which are potentially preventable. Their health status reflects a combination of socioeconomic and cultural factors. Pacific people tend to have lower levels of formal education and lower incomes than the total New Zealand population, which contribute to their poor health status. In addition, family and household characteristics, such as the greater incidence of extended families and one-parent families, as well as large family and household size, affect household income, living standards and housing needs.75

Pacific people are less likely than others to own their homes and tend to live in homes that are more ‘crowded’ than others. The relatively poorer economic position of Pacific peoples affects their level of homeownership and the location in which they live. In addition, Pacific family and household sizes tend to be larger. In 2001, 29 percent of the Pacific population was living in an extended family, compared with eight percent nationally. Household size can directly impact on housing situations and the level of disposable personal and household income.75 The size and range of housing available tends not to reflect the needs of extended families.

Early results from the Pacific Island Families Study indicate an association between housing conditions, housing costs and ill-health. The initial data set from the study found that damp and cold housing was common among respondents and significantly associated with a number of variables, including financial difficulty with housing costs, large household size and state rental housing. In addition, damp and cold housing were both significantly related to maternal depression and the incidence of asthma among household members.88

6.6.2 Current trends in housing in New Zealand (based on The Social Report 2004)

♦ In 2001, 24 percent of households spent more than 30 percent of their income on housing costs. There has been a substantial increase in the percentage of people spending more than 30 percent of their income on housing, the sharpest rise being between 1988 and 1993.
Ethnic differences in housing affordability are marked, with the difference between European and non-European households widening between 1988 and 1998. Eight percent of Māori households in 1988 spent more than 30 percent of their income on housing, rising to 32 percent in 1998 and 2001. For Pacific households the rise was from 15 percent in 1988 to 43 percent in 1998 and 2001. For ‘other’ ethnic groups the proportion increased from 37 percent in 1993 to 54 percent in 1998, largely because of an increase in new migrants. Across the population the rise was from 16 percent in 1988 to 42 percent in 2001.

Housing overcrowding is more likely to be experienced by younger people than older people, and by Pacific people compared with other ethnic groups. Economic conditions and cultural attitudes may account for the large differences between ethnic groups.

Unemployed people are more likely to be living in crowded conditions than those in full time jobs (20 percent and 6 percent) and rented houses were more likely to be crowded than owned houses.

6.7 Area of Residence

The socioeconomic level of the small geographical areas in which people live (small area deprivation) is a predictor of variation in health status. This relationship is reflected in the New Zealand Index of Deprivation (NZDep) that provides a socioeconomic deprivation score from 1 (least deprived) to 10 (most deprived) for small geographical areas. The NZDep was developed from information obtained in the 1991 and 1996 census and is based on the following indicators: access to a telephone, access to a car, income level, employment status, educational qualifications, home ownership, living in a single parent family, and living space.

Figure 8 shows a life expectancy gradient, where the more deprived the locality, the lower the life expectancy. Men’s lower life expectancy exists across the entire socioeconomic gradient.
In New Zealand, people who live in deprived areas are more likely to experience poor air quality, high risk water supplies, and low quality housing that has a higher likelihood of being built on a contaminated site. They experience increased hospitalisations, total mortality, injury related mortality, asthma prevalence in adults, sudden infant death syndrome (SIDS), and mortality due to causes that are potentially preventable by medical treatment. Small area deprivation has been identified as an important predictor of childhood mortality. Except for cancers other than lung cancer, each cause of death has a strong association with small area deprivation.

In general, when people move they exacerbate the inequalities in health that exist between different geographical areas through their migration. Healthier people end up living in affluent areas and less healthy people living in the worst-off areas. The association between the deprivation level of an area and people’s health status is explained in part by other related factors. For example, the location of people’s residence influences their employment opportunities and people’s employment opportunities influence where they live. However, not all socioeconomically deprived people live in deprived areas.

Nearly half of all Māori live in Auckland, Waikato or the Bay of Plenty. Within cities, Māori are unevenly distributed. In Auckland, where nearly a quarter of all Māori in New Zealand live, over half are resident in Manukau City and Auckland City. While other regions contain fewer Māori, Māori still constitute a significant proportion of the population in many regions of the North Island. An example is Māori living in Gisborne who make up four percent of the total Māori population across the country, but 42 percent of the total population of the Gisborne region.

The geographical distribution of Pacific peoples in New Zealand reflects the settlement patterns of Pacific migrants. Ninety-eight percent of the Pacific population is urbanised, with 66 percent living in the Auckland urban areas. Pacific people living in Auckland are more likely to live in crowded conditions than are Pacific people in other locations. The higher cost of living in Auckland and the high proportion of recent immigrants arriving there are likely to be contributing factors.

### 6.8 Access to health care

For most people in New Zealand, access to primary health care is subsidised but not free. Primary care providers, particularly general practitioners, often act as gatekeepers to other forms of health care or for access to health and disability-related financial assistance.

A number of New Zealand studies have shown that cost is likely to be a barrier to those with below-average incomes. The Commonwealth Fund 2001 Survey also found that Māori adults were twice as likely as non-Māori to have gone without health services because of cost. This difference partly reflected differences in income. The cost of filling prescriptions is also a barrier to effective treatment. The New Zealand Poverty Measurement Project identified 10 percent of Māori surveyed reported not filling their

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xii Low-income people are further subsidised on presentation of a community services card or through their enrolment in access Primary Health Organisations (PHOs).

xiii Such as the Disability Allowance and Child Disability Allowance
prescription due to cost. A recently announced drop in prescription charges for those enrolled in access Primary Health Organisations is expected to assist in increasing uptake of prescribed medicines.

The costs of health care can add to financial pressures on families with young children.97 Compared to other countries with similar profiles, New Zealand has relatively high charges for primary health care.98 Many families access their health care through Accident and Emergency Departments to avoid the cost. This puts pressure on an already stressed service. Even where the child’s visit is free or at low cost, payments for other family members or debts to the health service may inhibit access to health care.98 Cost is the most commonly reported reason for choosing not to take children to a general practitioner when they are unwell.99 However, implementation of the Primary Health Care Strategy over the next few years should lead to reductions in charges for primary health care.

The establishment of Primary Health Organisations to increase low cost access to primary health care in areas with high numbers of low income, Māori and Pacific people, has the potential to significantly improve health status in those areas. The earlier policy of free access for children under six has removed a significant cost barrier for families of young children. The proposed extension of the Primary Health Strategy will gradually lead to low cost access for all.

As indicated in the results from the Economic Living Standards Index developed by MSD (see section 6.2.3), in low income households children’s access to health services may be limited because of the family having to cut back on its expenditure. This often means that children miss out on the fully subsidised health services to which they are entitled, such as immunisation, oral health and hearing and vision services. Kidslink, a child health register that enables health providers to identify children who are missing out on services, has been shown to increase immunisation coverage to over 90 percent in pilot sites. This approach has the potential to be expanded to cover other primary health services.

However, cost is not the only barrier to accessing health services. An increasing body of evidence suggests that there is differential access to health care between ethnic groups both internationally and in New Zealand. Māori receive fewer cardiac interventions than the general population in spite of a higher mortality from cardiovascular disease100,101 and Māori have higher mortality rates from cancer after diagnosis. This suggests that improvement in the delivery of health services to Māori could make an important contribution to addressing health inequalities. Similar differential service provision also exists for Pacific people and for people in rural areas.

Recent migrants may also face specific difficulties in accessing health services through lack of information on available services and language barriers.75
Summary

♦ The socioeconomic determinants of health impact differentially across the population creating health inequalities

♦ As income decreases, rates of poor health increase

♦ Poverty is multidimensional and its effects are felt across the lifecourse

♦ Children from poor families have higher rates of illness, injury and death than other children

♦ Unemployment and low levels of education are related to poor health outcomes

♦ Death rates decline with each step up in occupational class

♦ High housing costs contribute to considerable hardship for low-income families and have a strong influence on health. People on low incomes are most likely to live in poor and/or crowded housing

♦ The deprivation level of the small geographical areas in which people live is a predictor of variation in health status

♦ Cost tends to be a barrier to accessing health care for people on low incomes. There is a differential access to health care between ethnic groups, which is independent of cost.
7 EXPLANATIONS FOR SOCIOECONOMIC DIFFERENCES IN HEALTH

7.1 Social capital, income inequality and health

A general explanation of inequalities in health that has recently been proposed is that of social capital. The term was developed outside the public health sector and includes factors like levels of participation in community organisations and activity, level of trust in others and levels of interaction that encourage cooperation for mutual benefit.

It has been argued that greater income inequality within a society is associated with increased mortality. One 2001 study cites evidence that greater income equality is associated with increased trust. There is also some evidence that suggests that the social environment becomes less supportive where there are greater income differences. For instance, there is a strong relationship between greater inequality and increased homicide, as shown by a meta-analysis of 34 studies.

The social capital/income inequality explanation for socioeconomic differences in health was given some prominence in the NHC 1998 report, but subsequent research has tended to diminish, rather than strengthen, the importance of social capital as the key to understanding socioeconomic differences in health. The reported association between income inequality and health at the international level was largely due to the choice of countries included in the analysis and the association is not evident when all available countries are included. The associations of income inequality and/or social capital with health within countries largely or completely disappear when the analyses are adjusted for ethnicity and/or individual income. In general, the evidence now shows that social capital, and related psychosocial factors have, at most, a very small independent effect on population health (over and above the effects of material conditions and individual socioeconomic factors such as individual income). This does not mean that social capital is not important in terms of social and community development. But it does mean that social capital does not appear to explain the major socioeconomic and ethnic differences in health in New Zealand and internationally.

7.2 Materialist explanation

The materialist explanation focuses on the impact of the material environment in which people live their lives. It is to do with having sufficient income to purchase the basic necessities of life such as warm, dry shelter, healthy food, and the ability to participate in society. It is also to do with access to education and employment, the basic prerequisites of an adequate income.

Under this explanation, it is primarily the material conditions, rather than income inequalities, that explain the observed association between income inequality and health. Thus,

"jurisdictions that allow income inequality to increase may often be those that also systematically under-invest in education, welfare, health care and a range of social institutions that serve as safety nets for people in unfavourable circumstances".

This under-investment in social structures may have health consequences.
The materialist explanation is not in direct conflict with the social capital/income inequality explanation but each theory leads naturally to different types of interventions. Current evidence indicates that the materialist explanation may have greater potential to inform the choice of interventions to improve health and reduce inequalities.\textsuperscript{110} This, along with the strength of evidence associating material circumstances and health, are the reasons for the PHAC emphasising the materialist explanation in this report.

### 7.3 Explanations for Māori health status

Some of the difference in life expectancy and in general health status throughout life, between Māori and non-Māori, can be attributed to Māori being disproportionately represented in economically disadvantaged groups.

Advantage or disadvantage conferred by ethnicity also impacts on health over and above the effect of income. For example, Māori on high incomes still have a 40 percent higher death rate than low-income non-Māori.\textsuperscript{44} In order to reduce inequalities in health, it is vital to understand factors operating differently on different ethnic groups as well as the causes that produce socioeconomic disadvantage.

A number of explanations have been put forward for ethnic disparities in health. The Decades of Disparity report identified epidemiological explanations (risk factors and disease), macroeconomic and social structural explanations (e.g., social and economic change in the 1980s and 1990s) and differences in access to, and quality of, health care services.\textsuperscript{23}

#### 7.3.1 Macroeconomic and structural explanations for Māori health status

The 1980s and 1990s were periods of major macroeconomic and social change in New Zealand. The evidence shows that the reforms impacted differentially on Māori and non-Māori. In 1984, a meeting of Māori leaders (Hui Taumata) foresaw the impacts of the reforms and warned even as early as 1984 that these reforms would use Māori as the “shock absorbers in the economy”.\textsuperscript{111}

During this period, the gap in life expectancy between Māori and non-Māori widened. This gap was the result of little or no increase in Māori life expectancy while the life expectancy of the general population was increasing. This is an indication of the differential and adverse impacts that macroeconomic and social structural changes can have on Māori health.

These trends show the importance of incorporating health impact assessment\textsuperscript{xiv} in the development of macroeconomic policies, and specifically focusing on the potential impacts on Māori health.

The most recent life expectancy figures show that Māori life expectancy is starting to increase, and at a greater rate than non-Māori life expectancy.\textsuperscript{xxv} A number of factors are probably responsible for this including general improvements in economic performance, Māori development and investment in “by Māori for Māori” health services.

\textsuperscript{xiv} Health impact assessment is discussed in Section 8.5.1

\textsuperscript{xxv} Data from Statistic New Zealand website: \url{www.stats.govt.nz}. Accessed 2 June 2004
Historical and contemporary influences

There are also historical influences that have affected Māori health across generations, for example, loss of resources, culture and language. These effects have been manifested in loss of self-identity for Māori, a major contributor to comparative poverty and ill-health, and an apparent decrease in trust in government.

Given the initial historical impact of colonisation, it could have been expected that Māori would have slowly recovered over the generations to a level of equality with non-Māori. That this has not happened highlights the importance of continued sensitivity, being alert to the possibility that there may be contemporary structural factors that perpetuate historical injustice, such as institutional racism. This occurs where the culture of an institution is such that it reduces access for some groups to the opportunities presented by society. This type of racism contributes to the unequal distribution of economic determinants of health such as employment and income.

7.3.2 Risk factors as explanations for Māori health status

Much of the research on the factors that cause cancer, cardiovascular disease and respiratory disease has been focused on ‘risk factors’ such as body mass index (BMI), high blood pressure or tobacco use. Māori are known to have smoking rates, BMIs and blood pressure consistent with disparities in mortality. However, research has tended to address lifestyle issues and behaviour out of the social and economic context of people’s lives.

Social and economic factors largely determine the distribution of risk factors in New Zealand society. Tobacco use is an example. A strong association has been reported in New Zealand between smoking and deprivation, and a negative association between tobacco use and increasing income. Those on low incomes may not be able to afford healthy food. Strategies for intervention of risk factors of disease must take into account the social and economic environment in which people live.

7.3.3 Health Service Explanations: Access and Quality

There is some evidence showing differential access to, and quality of health care between Māori and non-Māori. An example is that despite a higher mortality from cardiovascular disease, Māori receive fewer cardiac interventions than would be expected. There are also higher cancer death rates for Māori compared with non-Māori once they have cancer, suggesting that health services may play a part in health inequalities. These differences are unlikely to account for all of the disparities in outcomes between Māori and non-Māori, but they are likely to be among the contributors to the inequality (see also section 6.8).
Summary

- Evidence for the effect of socioeconomic factors on health is accumulating and becoming more convincing, but less is known about the reasons for this effect.

- Explanations include social capital/income inequality, and material resources. Evidence is strongest for the effect of people’s material circumstances on health.

- Large differences in mortality exist between ethnic groups even after allowing for differences in income.

- Explanations for the differences in health status between Māori and non-Māori include macroeconomic and structural factors, as well as differences in risk factors for disease, and differences in access to appropriate health care services.
8 POLICY INTERVENTIONS

Public health policy in New Zealand has led to the development of a focus not only on health gain across the population, but also with the additional commitment to reducing inequalities. This greater emphasis on tackling health inequalities has become a trend in many countries in the developed world.

The way that health inequalities are defined will determine the way that policy is developed to address them. Graham (2004) points out that:

“while offering policy advantages, defining health inequalities as disadvantages is not without its problems. It turns inequality from a structure which impacts on all, to a condition to which only those at the bottom are exposed.”

Defined in this way, policy development would not lead to a population-wide approach, but would instead focus on small groups within the population (targeting).

A further definition places health inequality in terms of health gaps – “the difference in health between the worst off and better off groups” or also as “the health differentials between those in the poorest circumstances and the average for the population”. Either of these definitions places “the burden of ill-health resulting from socioeconomic inequality on the poor alone”. Once again, policy is directed at minorities and “will not deliver the relative improvements needed among those in the middle tiers of the socioeconomic structure to reduce health inequality across the population”.

However, policy that tackles the socioeconomic gradient in health tackles the correlation between social class and health at every level. The WHO constitution states that the highest attainable standards of health should be within reach of all “without distinction for race, religion, political belief, economic or social condition”. It is in this paradigm that the PHAC has developed its recommendations to the Minister of Health.

8.1 The links between economic policy and health

Although the evidence of the direct effects of policy interventions on health and health inequalities is mostly not sufficient to give totally unambiguous advice to policy makers, there is evidence to suggest that the relationship between socioeconomic position and health outcomes is modifiable by policy.

- Costa Rica was an impoverished, mostly illiterate population with a low life expectancy. In 1948, the government disbanded the army and spent the military budget on health and education. This commitment to social spending has remained to the present day. Costa Rica now has almost no illiteracy and compared with other Central American countries, it has the highest life expectancy, the lowest child mortality and the best economic output per person.

- In the UK, increasing health inequalities have reflected widening social inequalities that have come about as a result of changes in policy direction. Improvements in life expectancy have been much greater in people from advantaged socioeconomic groups and decreasing down the socioeconomic gradient. A similar pattern has been described in New Zealand associated with economic and social changes in the 1980s and 1990s.
A recent UNICEF study of 17 OECD countries compared the actual rate of child poverty with the rate that might exist without certain tax and benefit policies. It found that the Nordic countries, which have low rates of child poverty, have extensive public assistance policies. These policies include paid parental leave, childcare for working parents and universal redistribution policies. It has also been shown that in countries where there are strong social assistance policies, such as Sweden, the effects of poverty may not be as damaging to health as countries such as the UK with less support for low-income people, indicating a protective mechanism is operating.

In the UK, child poverty has been reduced by 25% over the five years to 2004. Much of this success has been attributed to the introduction of Child Tax Credits that provide a ‘single, seamless system’ of much increased support to families with children, regardless of the employment status of their parents. It might be expected that this will result in positive health outcomes, knowing the links between poverty and health.

The New Zealand Poverty Measurement Project has identified five areas of government policy that have the potential to contribute to poverty reduction in New Zealand. These are: lifting the threshold for New Zealand Superannuation; the reintroduction of income related rents on state houses; the promotion of an ‘employment rich’ economy and reducing unemployment; the primary health care strategy; and the stated intention to reduce child poverty through income support. Since poverty is a strong indicator of poor health, there is good reason to believe that these policy directions will have a positive effect on health.

There is a paucity of evidence related to the differential effects of policy interventions, many of which seem to have improved the health of the most well-off more than the at-risk groups. It is crucial that this type of evidence is collected and that policy interventions address the socioeconomic gradient in health and not solely the health gap between rich and poor or between Māori and non-Māori. There is some evidence to suggest that single policy interventions may not be as effective as a mix of policies.

Gaps in evidence present governments with policy challenges. It is tempting for a government to do nothing until the evidence is convincing, or to restrict its interventions to those designed to modify individual behaviours for which there is more evidence. More research needs to focus on directly informing policy, and on testing interventions to increase understanding of how effective interventions should be implemented.

8.2 Nature of evidence used in policy development

There is increasing acknowledgement that policy and practice need to be evidence/knowledge-based but more clarity is needed about what constitutes evidence.

In the health sector, a hierarchy of evidence is used, at the apex of which sits systematic reviews of randomised controlled trials, followed by case-control and cross-sectional studies, with observational studies and professional consensus being much lower on the hierarchy.

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xvi The official poverty line in the UK is 60 percent of the median income level – where the median is the level of income after direct taxes and benefits, adjusted for household size, such that half the population is above the level and half below it. It is a measure of relative poverty.
This hierarchy has been contrasted by Davies and Nutley (2002) with levels of evidence in sectors underpinned by the social sciences (eg, education and social care) where there is little experimentation and much division between quantitative and qualitative approaches. The authors advocate the need for agreement about what constitutes evidence in different types of policy development. They point out the large gaps and ambiguities in the knowledge base that informs policy development across sectors. However, they also promote the concept of ‘evidence-informed’ policy, implying that policy is never totally evidence-based because of other influential factors such as political views. Evidence-informed policy gives the flexibility to take evidence into account while acknowledging other valid influences.

There is a need for policy-making to use the best evidence available. The evidence may not always be ‘gold-standard’ but good quality evidence will indicate the direction a policy should take, identifying a goal to be moving towards. The nature of policy-making means that the development of new policies often has unintended consequences, so is in a sense experimental. It should therefore build in means to monitor its success in moving towards a goal, allowing for resultant changes where necessary. Evaluation of policy should be an important part of building the evidence base.

There is also a need to widen concepts of what constitutes evidence to incorporate such approaches as impact assessments, forecasting, scenario-building, public inquiries, action research and the legal process.

In New Zealand, the lack of evidence on the pathways associating the determinants of health with Māori health outcomes is a barrier to understanding how to address them. More understanding is needed, particularly about the part ethnicity plays in determining health outcomes, over and above socioeconomic circumstance.

8.3 Universal and targeted policy approaches

Policy interventions may be universal, where policies provide equal benefit across the population, or targeted, providing benefit to groups in greatest need. They may also be a mix of universal and targeted approaches.

Critics of universal approaches state that these policies create the potential for “waste” when benefits are given to those who may not need them. On the other hand, supporters cite a range of reasons for universal policy interventions. In the area of child poverty, the following arguments have been suggested for using a universal approach:

♦ Universal assistance recognises that households with children face higher costs for all income brackets compared to equivalent households with no children.

♦ Since it is today’s children who will be the workforce of the future, there is a strong public good argument calling for redistribution between households with no children towards households with children at all income levels.
Universal assistance is inclusive and avoids the social ostracism that is associated with targeted welfare programmes.\textsuperscript{xvii}

During the economic reforms of the late 1980s and early 1990s, universal policies for children were abandoned for targeted provisions. It has been argued that a universal comprehensive policy framework for all children, not just those at risk, would be most effective. Targeting is based on the identification of ‘high-risk’ groups but health inequalities are distributed across society and are not just confined to deprived people.

A large number of people at small risk gives rise to more cases of a disease or disorder than a small number at high risk. Therefore it is more effective across a population to have a policy that benefits a larger number of people. However, targeted approaches may be beneficial where risk is low and the target population is easy to identify and access.

Recent literature mainly advocates universal assistance or a mix of universal and targeted approaches, the latter ensuring that no one in need misses out on universal benefit. A recent New Zealand report found that many eligible Māori and Pacific families are missing out on the Disability Allowance and may therefore be missing out on access to primary health care.\textsuperscript{124} A similar situation was identified in 2000 with Special Benefit and subsequent improvement in delivery has resulted in an increased uptake.

Policy interventions to address disparities in health are more likely to be successful if they employ a range of strategies and a mix of universal and targeted approaches based on a variety of relevant measures. Some degree of targeting needs to be employed to ensure that universal policies reach those who especially need them.

\subsection*{8.3.1 Locality-based targeting}

Locality based targeting is a convenient way to allocate funding for services, such as primary health care, based on community need rather than individual need. NZDep (see section 6.8) provides a means to easily identify deprived areas. However, given that not all deprived people live in deprived communities and that the index does not include ethnicity, this type of targeting used alone, will only reach some of those in greatest need.\textsuperscript{125}

\subsection*{8.4 Framework for policy intervention}

The framework for intervention the PHAC has chosen for this report is that used in the Ministry of Health’s “Reducing Inequalities in Health” publication which is based on the Mackenbach points of intervention model.\textsuperscript{126} (See Figure 9 below). This identifies four points at which there could be effective policy intervention:

\begin{itemize}
  \item Level 1 – at the structural level where the root causes of health inequalities can be addressed, ie, the social, economic, cultural and historical causes of ill-health (the wider determinants of health). Examples of interventions at this level would include policies that ensure equitable access to education, labour market, housing and other social outcomes, and ensure that all policies are assessed for their impact on health and health inequalities. It is at this level where interventions have the greatest potential to influence the socioeconomic determinants of health.
\end{itemize}

\textsuperscript{xvii} Based on information provided by the Child Poverty Action Group
Level 2 – at the intermediate level where the effects of the wider determinants of health are mediated by access to material resources, lifestyle, and physical and social environments. Examples of interventions at this level include settings-based programmes such as healthy cities and workplace interventions, local authority policies, community development programmes and health education.

Level 3 – access to health and disability services can be improved by removal of barriers to access, monitoring of services to ensure equity of access, and community participation in health care decisions.

Level 4 – to reduce the impact of ill-health on socioeconomic position (the feedback effect). Examples of interventions at this level include income support, disability allowance and accident compensation.

There is no single intervention point that will reduce health inequalities. Policies need to cover all four levels for greatest effect, although the more ‘upstream’ (Level 1) approaches have the greatest potential to influence the social and economic determinants of health. This report and its recommendations therefore places emphasis on Level 1.

8.5 Intersectoral collaboration in policy-making

As socioeconomic inequalities in health are explained by a combination of factors rather than by single factors such as income alone, policy interventions should be comprehensive in their approach. Given that the greatest influences on health originate in other sectors, an organised, intersectoral effort will be needed to address the fundamental causes of health inequalities.
One of the major barriers to cross-sectoral collaboration in recent years has been the Public Finance Act 1989 and Fiscal Responsibility Act 1994. These pieces of legislation increased accountability, but ‘silied’ funding made intersectoral collaboration very difficult. For example, the cross-sectoral funding of “Strengthening Families” was problematic. The PHAC is pleased that the Public Finance (State Sector Management) Bill has responded to the Review of the Centre recommendations to support better integration and greater flexibility in managing funding streams across sectors.

Some ‘clustering’ projects have been recently established to bring together relevant government agencies to address community renewal, to colocate work and income with housing in some areas, and to address “youth care to independence”.

There are challenges to implementing intersectoral action where the timeframes are long for measuring effectiveness and where institutional culture has not moved from the silo mentality. However, assessing policies for their impact on health is one way of ensuring that policies from other sectors do not impact adversely on health and health inequalities.

8.5.1 Health Impact Assessment

As the strongest influences on health come from factors outside the control of health services, policies from sectors other than health have a great potential for improving health and wellbeing and for reducing health inequalities. However, they have a similar potential to have adverse effects on health and for this reason, should be assessed for potential impacts prior to implementation.

All significant public policy should be assessed for its impact on health and well-being. Any process used can identify and reduce any possible negative effects, and enhance any positive effects by applying assessment tools early in the policy development process, to allow time to adapt the policy for maximum benefit.

The PHAC has developed a tool to assist policymakers to assess the potential impact of policies outside the health sector for their impact on health.127


The PHAC developed this practical guide to assist policymakers in all sectors of central and local government to consider health during the policy development process.

Health impact assessment (HIA) is a formal approach used to predict the potential health effects of a policy, with particular emphasis paid to impacts on health inequalities. It is applied during the policy development process in order to facilitate better policy-making that is based on evidence, focuses on outcomes and includes input from a range of sectors. HIA enriches the policy-making process, providing a broader base of information to make trade-offs between objectives where necessary and to make explicit the health implications of those trade-offs.

xviii The Report of the Advisory Group on the Review of the Centre was presented to the Ministers of State Services and Finance in November 2001. It proposed improvements in three areas: integrating service delivery across multiple agencies; addressing fragmentation of the State sector and improving its alignment; and improving the systems under which State servants are trained and developed.
The guide developed by PHAC describes HIA and its benefits and provides a practical step-by-step description of how to undertake a health impact assessment.

The guide can be downloaded from the PHAC website: www.nhc.govt.nz/phac.html or copies ordered by phoning 04 496-2277 or emailing moh@wickliffe.co.nz.

8.5.2 Social reporting

The social reporting cycle from the Ministry of Social Development has developed a series of ten ‘desired social outcomes’ with attendant indicators to measure progress in each of the chosen areas. These social outcomes together set out a vision for:

“an inclusive, prosperous and environmentally sustainable New Zealand. People in New Zealand want this nation to be a place where all individuals are able to achieve their full potential, where all have the opportunity to participate in a vibrant and growing economy, and where our environment is enjoyed by both current and future generations.”128 (See Appendix Three for summary.)

The PHAC believes these social outcomes to be an excellent start to having a shared vision for New Zealand and a good framework within which to develop actions that move us towards these high level goals.

However, the value of these desired social outcomes goes beyond simply their use as a basis for measuring progress. The outcomes collectively describe a vision of social goals for a quality of life for all people in New Zealand. These social goals should be the benchmark for all central and local government policy development. A cross-sectoral action plan would be based on these broad goals with a series of objectives to guide policy development.

8.5.3 Budget 2004

The Budget 2004 Working for Families package took some important steps aimed at raising the income levels of working families. Its key objectives are: to make work pay; ensure income adequacy; and to achieve a social assistance system that supports people into work. The thrust of this Budget package will be beneficial to working families on low incomes, but children from families whose only source of income are welfare benefits, will not benefit unless the employment status of their parents changes. Any government policy to reduce child poverty needs to address this discrepancy.

8.5.4 The sustainable development programme of action

The government is seeking progress through the Sustainable Development Programme for Action, in which economic, social, cultural and environmental concerns are all given equal status. It will be largely driven at the local level by local government in partnership with their communities. The wider determinants of health will be under consideration. The challenge will be to ensure that health and wellbeing are not only considered, but are central to the effective implementation of sustainable development policies. The health sector needs to be visible and active at both nationwide and regional levels.
8.5.5 The growth and innovation framework

The 2002 Growth and Innovation Framework (GIF) is the government’s statement of its economic direction. It is clearly based in concepts of sustainability, stating that

“the choice of economic policy instruments will be influenced by their interaction with social and environmental factors.”

This framework however, is almost silent on the links between economic development and health and wellbeing, although it notes that a healthy population is an “important foundation for sustaining our economy”. This makes it all the more important that the health sector establishes an ongoing role in the implementation of this framework. Health impact assessment tools have the potential to make a difference to these economic development approaches.

Summary

♦ The evidence for a direct causal relationship between specific government policy and health outcomes is generally ambiguous, but there are indicators that suggest that socioeconomic position and resulting health outcomes are modifiable by policy

♦ Policy interventions to address disparities in health are more likely to be successful if they address the socioeconomic health gradient and employ a range of strategies and a mix of universal and targeted approaches

♦ Organised intersectoral collaboration is required to address the fundamental determinants of ill-health, with policies routinely assessed for their potential impact on health (health impact assessment).
9 PRIORITIES FOR ACTION

A wide socioeconomic gradient of health status exists among people living in New Zealand. Those sectors of the population who have low incomes, live in sub-standard or crowded housing, and have low levels of education tend to have the poorest outcomes for health and associated measures of wellbeing. Health status improves with each improvement in socioeconomic status. The differences in life expectancy between ethnic groups have widened in recent decades although there are early signs of some improvement.

Economic and social policies affect the socioeconomic determinants of health, such as income, employment, housing and education. In turn, these determinants influence health and wellbeing outcomes, either positively or negatively.

Changes to economic policy and socioeconomic conditions particularly affect those with low living standards and education. Their health is most affected by adverse socioeconomic conditions, such as unemployment and high housing costs, which in turn lead to ill-health. Conversely, those sections of the population with higher living standards tend to have better levels of health. The challenge is to achieve a level of health for the whole population that is equivalent to that of the highest socioeconomic deciles.

Economic growth is essential to improve overall living standards but not sufficient to improve the health status of those in poorest health and reduce health inequalities. International data suggest that it is also important to distribute the benefits of economic growth to all members of society through social investment and social protection.

This report shows that policy interventions to address socioeconomic inequalities have the potential to improve health outcomes – that governments can make a difference.

The complexity of causal pathways between economic and socioeconomic factors and health outcomes provides a challenge to policy makers. It also indicates the importance of developing policy across sectors in a co-ordinated way. The PHAC has highlighted the importance of this in its recent guide on health impact assessment.

In preparing this report, the PHAC considered the question of how economic and social policies can improve the health of all people and communities to the same level as those who enjoy the best health. Its findings are in line with the quote from Geoffrey Rose at the beginning of this report – that because social and economic factors are the main determinants of health, solutions will lie in social and economic policy.

The committee recognises that its expertise lies in public health rather than in detailed economic and social policy, and so has identified high level policy actions that it believes are required to reduce the socioeconomic gradient in health outcomes.

The evidence in this report particularly indicates the importance of good socioeconomic circumstances in childhood. Addressing child poverty is a priority for improving health in New Zealand. Not only will this improve the health of a vulnerable part of the population, but it will also contribute to future benefits for the country. Reducing poverty also has the potential to improve quality of life, participation in all aspects of society and contribute to economic growth.

In order to identify what progress has been made in reducing poverty, a benchmark is needed against which progress can be monitored. The PHAC recommends adopting an official poverty measure to do this.
The PHAC also recommends the routine reporting and analysis of data on socioeconomic status, ethnicity and health so as to directly monitor progress toward the reduction of socioeconomic and ethnic differences in health outcomes. Funding research to identify effective policy interventions for reducing health differences and for developing a better understanding of the causal links between socioeconomic status, ethnicity and health is also recommended.

While reducing socioeconomic differences between Māori and non-Māori will go some way to improving Māori health, there are other factors contributing to poor Māori health status. More understanding of the pathways associating ethnicity and health is needed to be able to fully address these disparities.

As well as the overarching recommendations listed below, the PHAC has developed an example of a framework for policy development, based on some of the desired social outcomes listed in The Social Report 2004. This framework is presented in Appendix Four. It identifies possible policy objectives for the five social outcomes related to economic and socioeconomic factors, and provides examples of policies that could be adopted to meet these objectives. The committee understands that the Government’s work on Opportunities for All is in line with this proposal.

While the PHAC provides advice to the Minister of Health, the actions identified in this report relate to both health and wider measures of wellbeing and require changes in other portfolio areas. The committee therefore recommends that the Minister of Health share this report and its recommendations with ministerial colleagues.

9.1 Recommendations

The Public Health Advisory Committee recommends to the Minister of Health that the New Zealand Government:

1. Adopts the goal of improving the health of all, without distinction for ethnicity, social or economic position, to the same level as those who have the best health.

The Public Health Advisory Committee recommends that the following actions be taken toward the realisation of this goal (the goal):

2. Develop an official poverty measure by July 2005, set measurable objectives for the reduction of poverty and monitor progress toward meeting these objectives.

3. Aim to reduce child poverty by at least 30 percent by 2007, and make continuing improvements until child poverty is eliminated in New Zealand.

4. Assign to an appropriate body ‘whole of Government’ responsibility for co-ordinating policies and monitoring effects on health inequalities.

5. Develop the capacity for health impact assessment to ensure consideration of the effects on health of central and local government policy during the process of policy formation.

6. Require the routine reporting of data on socioeconomic status, ethnicity and health at the national and district health board levels. This should include analyses by socioeconomic status within ethnic groups.

7. Fund research for identifying policy interventions that reduce health inequalities and to better understand the causal paths linking socioeconomic status, ethnicity and health.
APPENDIX ONE: MEASUREMENT ISSUES

In describing the associations between socioeconomic factors and health the PHAC acknowledges the following:

- No one method of measuring socioeconomic status captures the whole association with health. Occupational measures of socioeconomic status are widely used in public health research, largely because of accessible information, the fact that occupation gives a good indication of where people are in the social structure and is a more holistic concept than income or education.\(^{131}\)

- Measurement error of socioeconomic factors is most likely to underestimate the contribution of socioeconomic factors to ethnic differences.\(^{23}\)

- Ethnicity is an independent predictor of health and compounds socioeconomic differences in health. Equivalent values of socioeconomic status measures represent important differences in social and economic circumstances for people of different ethnic groups.

- Successive censuses in New Zealand have used different questions to identify ethnicity. Also between 1981 and 1995, the recording of ethnicity data on death certificates was different from that on the census. This has created difficulties for data collection and analysis.

- Different health conditions vary in the time lags between cause and effect. For example, the effects of unemployment on mental health are likely to be rapid, but the effects of deprivation on chronic disease may well take decades to present.

- There is concern among disabled people about the use of DALYS (Disability Adjusted Life Years) to measure health outcomes, which they believe devalues the lives of disabled people. Potential years of life lost and life expectancy are less value-laden measures.
APPENDIX TWO: RECENT GOVERNMENT STRATEGIES

New Zealand Health Strategy (NZHS)

The NZHS states that the way to improve the population’s health is to focus on those factors that most influence health, including income, education, employment, housing and access to health care services. It emphasises the need to focus attention on those with the poorest health to reduce health disparities. It also advocates the assessment of policies for their impact on health.

New Zealand Disability Strategy (NZDS)

The NHDS emphasises the importance of employment and economic development to provide opportunities for disabled people to participate fully in society. This full participation is necessary for their overall health and wellbeing and to reduce disparities.

He Korowai Oranga

This strategy stresses the need to address disparities in health status that reflect broader socioeconomic inequalities experienced by Māori. It sets out government vision of whānau ora and pathways to achieving this vision. It acknowledges the need to address the wider determinants of health by working across sectors, for example, by influencing education, housing and labour market policies.

Primary Health Care Strategy

The Primary Health Care Strategy is underpinned by a goal of improved low cost access to primary care for all, but particularly those with the greatest health need. The strategy aims to improve health overall and reduce health inequalities. As part of the policy to reduce health inequities, Primary Health Organisations (PHOs) are funded according to the need of their populations. For example, Māori and Pacific people, people on low incomes and people with chronic conditions are known to have lower health status and higher health needs than the general population. This means that PHOs with high numbers of these populations enrolled with them, will have favoured funding weightings.

This strategy will break down cost barriers for those groups that most need access to primary health care. It has the potential to make a difference to health inequalities.

<table>
<thead>
<tr>
<th>Desired social outcome</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| **Health**             | ♦ Health expectancy  
 ♦ Life expectancy  
 ♦ Dependent disability  
 ♦ Suicide  
 ♦ Prevalence of cigarette smoking  
 ♦ Obesity. |
| All people have the opportunity to enjoy long and healthy lives. Avoidable deaths, disease and injuries are prevented. All people have the ability to function, participate, and live independently or appropriately supported in society. |
| **Knowledge and skills** | ♦ Participation in early childhood education  
 ♦ School leavers with higher qualifications  
 ♦ Educational attainment of the adult population  
 ♦ Adult literacy skills in English  
 ♦ Participation in tertiary education. |
| All people have the knowledge and skills they need to participate fully in society. Lifelong learning and education are valued and supported. All people have the necessary skills to participate in a knowledge society. |
| **Paid work**          | ♦ Unemployment  
 ♦ Employment  
 ♦ Average hourly earnings  
 ♦ Workplace injury claims  
 ♦ Satisfaction with work/life balance. |
| All people have access to meaningful, rewarding and safe employment. An appropriate balance is maintained between paid work and other aspects of life. |
| **Economic standard of living** | ♦ Market income per person  
 ♦ Income inequality  
 ♦ Population with low incomes  
 ♦ Population with low living standards  
 ♦ Housing affordability  
 ♦ Household crowding. |
| New Zealand is a prosperous society, reflecting the value of both paid and unpaid work. All people have access to adequate incomes and decent affordable housing that meets their needs. With an adequate standard of living people are well placed to participate fully in society and to exercise choice about how to live their lives. |
| **Civil and political rights** | ♦ Voter turnout  
 ♦ Representation of women in government  
 ♦ Perceived discrimination  
 ♦ Absence of corruption. |
| All people enjoy civil and political rights. Mechanisms to regulate and arbitrate people’s rights in respect of each other are trustworthy. The principles of the Treaty of Waitangi are recognised and incorporated into government decision-making.
<table>
<thead>
<tr>
<th>Desired social outcome</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| **Cultural identity**                          | ♦ Local content on New Zealand television  
♦ Māori language speakers  
♦ Language retention. |
| New Zealanders share a strong national identity, have a sense of belonging, and value cultural diversity. All people are able to pass different cultural traditions on to future generations. Māori culture is valued and protected. |                                                                                  |
| **Leisure and recreation**                     | ♦ Satisfaction with leisure  
♦ Participation in sport and active leisure  
♦ Experience of cultural activities. |
| All people are satisfied with their participation in leisure and recreation activities. All people have adequate time to do what they want to do, and can access an adequate range of different opportunities for leisure and recreation. |                                                                                  |
| **Physical environment**                       | ♦ Air quality  
♦ Drinking water quality. |
| The natural and built environment in which people live is clean, healthy, and beautiful. All people are able to access natural areas and public spaces. |                                                                                  |
| **Safety**                                     | ♦ Child abuse and neglect  
♦ Criminal victimisation  
♦ Perceptions of safety  
♦ Road casualties. |
| All people enjoy physical safety and feel secure. People are free from victimisation, abuse, violence and avoidable injury |                                                                                  |
| **Social connectedness**                       | ♦ Telephone and internet access in the home  
♦ Regular contact with family/ friends  
♦ Trust in others  
♦ Proportion of the population experiencing loneliness  
♦ Contact between young people and their parents. |
| People enjoy constructive relationships with others in their families, whānau, communities, iwi and workplaces. Families support and nurture those in need of care. New Zealand is an inclusive society where people are able to access information and support. |                                                                                  |
### APPENDIX FOUR: POLICY DEVELOPMENT FOR HEALTH AND WELLBEING

<table>
<thead>
<tr>
<th>Desired social outcome (based on the Social Report 2004)</th>
<th>Examples of policy objectives</th>
<th>Examples of policy options</th>
</tr>
</thead>
</table>
| **Economic standard of living**  
New Zealand is a prosperous society, reflecting the value of both paid and unpaid work. All people have access to adequate incomes and decent affordable housing that meets their needs. With an adequate standard of living people are well placed to participate fully in society and to exercise choice about how to live their lives. | ✷ reduced child poverty  
✷ economic policy does not adversely affect socioeconomic status  
✷ improved affordability of safe housing for people on low incomes, particularly for those households with children  
✷ reduced discrimination in employment and housing  
✷ reduced tax burden on low income families  
✷ improved housing quality particularly for those households with children | ✷ Develop a poverty reduction strategy across all levels of government with measurable goals and targets and clear roles and responsibilities  
✷ Implement the Agenda for Children and the Child Health Strategy  
✷ Increase collaboration between the housing, energy efficiency and health sectors to insulate older housing stock  
✷ State housing stock reflects the needs of extended families  
✷ Benefits for child rearing households to be inflation adjusted  
✷ Reintroduction of universal family benefit  
✷ Further family assistance for all low income families (not just for working families)  
✷ Raise tax threshold for low income families |
| **Paid work**  
All people have access to meaningful, rewarding and safe employment. An appropriate balance is maintained between paid work and other aspects of life. | ✷ reduced labour market discrimination  
✷ reduced unemployment rates for Māori  
✷ reduced unemployment rates for Pacific people  
✷ improved health and safety in the workplace  
✷ improved participation rates of women in paid employment  
✷ increased protection for children in paid work | ✷ Increase threshold for people on benefit to take on part time work  
✷ Regional economic development that develops jobs where people live  
✷ Greater flexibility in income support provisions to increase disabled people’s participation in the workforce  
✷ Childcare subsidies for public and private sector childcare/early childhood education centres |
<table>
<thead>
<tr>
<th>Desired social outcome (based on the Social Report 2004)</th>
<th>Examples of policy objectives</th>
<th>Examples of policy options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge and skills</td>
<td>♦ access to education and skills development throughout life</td>
<td>♦ reduce costs of education, in particular, early childhood education</td>
</tr>
<tr>
<td>All people have the knowledge and skills they need to participate fully in society. Lifelong learning and education are valued and supported. All people have the necessary skills to participate in a knowledge society.</td>
<td>♦ increased number of children leaving school with qualifications</td>
<td>♦ reduce student loan burdens, taking into account the lower earning potential of women</td>
</tr>
<tr>
<td>Physical environment</td>
<td>♦ economic development uses natural resources in a sustainable way</td>
<td>♦ the sustainable development strategy underpins all economic development policy at both regional and national levels</td>
</tr>
<tr>
<td>The natural and built environment in which people live is clean, healthy, and beautiful. All people are able to access natural areas and public spaces.</td>
<td>♦ economic development of natural resources occurs in partnership with iwi and hapu</td>
<td>♦ partnership and participation principles underpin all public policy at regional and national levels</td>
</tr>
<tr>
<td>♦ policies in other sectors do not have a negative impact on health</td>
<td>♦ equality of access to health services</td>
<td>♦ all significant policy to be assessed for its potential impact on health</td>
</tr>
<tr>
<td>♦ affordable access to healthy choices eg healthy food.</td>
<td>♦ in the Public Health Bill, allow for future tax on advertising of food that does not meet nutritional guidelines</td>
<td>♦ develop common understanding of the concept of health across agencies</td>
</tr>
<tr>
<td>♦ reduced student loan burdens, taking into account the lower earning potential of women</td>
<td>♦ universal free access to primary health care – gradual implementation</td>
<td>♦ reduce barriers</td>
</tr>
<tr>
<td>♦ remove GST from fruit, vegetables and milk</td>
<td>♦ in the Public Health Bill, allow for future tax on advertising of food that does not meet nutritional guidelines</td>
<td>♦</td>
</tr>
</tbody>
</table>
APPENDIX FIVE: LIST OF KEY CONTRIBUTORS

The PHAC thanks the following people and agencies who were generous with their time in providing information for this report. However, this report is from the Public Health Advisory Committee and as such, may not reflect all the ideas of key contributors.

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Housing New Zealand Corporation
Ministry of Economic Development
Labour Market Policy Group
Ministry of Health

Ministry of Pacific Island Affairs
Te Puni Kokiri
Ministry of Ethnic Affairs
Office for Disability Issues
Ministry of Women’s Affairs
Department of Prime Minister and Cabinet
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Howden-Chapman P. 2004. Preliminary results of the housing, insulation and health study. Presentation to Wellington School of Medicine Summer School on Housing and Health. 5 February.


“Ma te huruhuru te manu ka rere
Feathers enable the bird to fly”

“The primary determinants of disease are mainly economic and social, and therefore its remedies must also be economic and social.”
Geoffrey Rose (The Strategy of Preventive Medicine. 1992.)
The Health of People and Communities

A Way Forward: Public policy and the economic determinants of health

Report to the Minister of Health
From the Public Health Advisory Committee

October 2004