



Health inequities are rising unseen in New Zealand

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The article by Fenton¹ in this issue of the *New Zealand Medical Journal* raises very important issues for the New Zealand health sector.

The potential introduction of a scheme that allows public patients to access private medicines in a public hospital looks like a commonsense approach at first glance, but on closer examination it is clear that such schemes can seriously undermine health equity, as well as do longer term damage to the public health system. This example is the tip of the iceberg of equity issues that are currently impacting on the health of New Zealanders² as a recent review of differences in survival from colon cancer demonstrates.

In times of tight budgets, the pressure to mount such schemes will intensify. Rationing systems will be subject to even more pressure as harder choices will have to be made. The scenario that played out around Herceptin (trastuzumab)³ in the lead-up to the previous New Zealand general election foreshadows the tensions that will become increasingly apparent. In the Herceptin case, the real anguish experienced by individuals with cancer overwhelmed notions of safety, benefit and fairness across the system as a whole, and undermined a well-established process that had previously been developed by PHARMAC to deal with such issues.

The notion of an egalitarian society, where everyone has a fair go, is deeply embedded in the New Zealand society.⁴ Indeed, a strong belief in fairness is behind calls for access to new treatments described in Fenton's article. However, the irony is that many more New Zealanders die because we fail to provide them with access to the cheapest and most effective healthcare interventions, rather than because of lack of access to high-cost new treatments such as Herceptin. It is essential, therefore, that this fundamental social consensus is given expression at the policy level, and the impact on equity of different policy options is carefully considered.

Recent policy initiatives in the primary health care sector are also having an equity impact. For example, shifting secondary services to community settings in urban, well-served populations have been consistently shown to reduce efficiency and increase cost, with no improvement in health outcomes.⁵ In provincial settings it risks undermining the local hospital's viability.

Delivering secondary services in community settings is only likely to be cost-effective when targeted at under-served, disadvantaged populations. Similarly, the consolidation of smaller general practices, and a broader range of other services, into one larger polyclinic or Integrated Family Health Centre, offers some benefits in terms of improved management of chronic conditions, however there is little evidence to suggest that these benefits outweigh the marked reduction in access that will occur from centralising primary level care.⁶

Health systems are complex, and unexpected outcomes frequently occur from well-meaning policy initiatives. Unless equity is explicitly considered, even the best intentioned policies are likely to inadvertently widen rather than reduce health inequities. To not consider the impacts that new policies have on health inequities is now hard to justify.

Just as these tensions are playing out at the individual access to treatment level, a more profound health equity crisis is evolving (largely unseen) from the impact of other sectors. Indeed, the set of social conditions we are now experiencing closely resembles the set of social conditions in the late 1980s and early 1990s.⁷

The combination of rising unemployment, reduction in incomes for low-income families, and reduced access to social housing contributed to widening health inequalities between different population groups such as Māori and non-Māori and low and high income New Zealanders. This arrested (for several years) the historical movement that had been occurring for decades towards a more equitable society. Now that these same social conditions are upon us in 2011, the societal response remains unchanged, with little learning from previous experience.

Current responses suggest we only value equity as a goal when economic conditions are favourable, and are prepared as a society to countenance the reduction in life chances for the most vulnerable, including children, when resources are short. This is certainly unfair, but it also makes little economic sense—denying the potentially positive relationship between health equity and improved economic performance.⁸

Health equity will not just “happen” without strong commitment from government backed by strong support from the health sector. A recent policy statement from the NZMA on health equity is an excellent starting point.⁹ The health sector can contribute by seeking to ensure equity in access for the entire population, not just access to more services for those who get through the door.

The health sector also has a strong advocacy responsibility. Health inequities cannot be addressed by the health sector alone,¹⁰ but no sector is better positioned and mandated to advocate for whole of government action to address this preventable and unjust burden of death and disability. The health sector will have difficulty in urging other sectors to consider the health equity impacts of their policies, without leading by example.

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