Explanations for socio-economic differences in health

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Introductory comments for the discussion

Explanations for socioeconomic differences in health

Some history

The last twenty years

What can we do now?

- Do we need a New Zealand version of the Black report?
- What can we do to influence the policies of the other Government Departments?
- What can we do within the health services?

Some history

"Most travellers are struck by the lowness of stature, the leanness and the paleness which present themselves so commonly … among the factory classes…They wear out very early in consequence of the conditions under which they live and work. Most of them are unfit for work at forty years, a few hold out to forty-five, almost none to fifty."

(Engels, 1945)

Some history

"It is the great merit of E.G. Wakefield to have discovered…in the colonies, the truth about capitalist relations in the mother country…Wakefield's theory of colonisation…aims at manufacturing wage-labourers in the colonies"

(Marx. Capital)

Some history

"How can the anti-capitalist cancer of the colonies be healed?... Let the government set an artificial price [for land which] compels the immigrant to work a long time for wages before he can earn enough money to buy land and turn himself into an independent farmer. The fund resulting...is to be applied to the importation of paupers from Europe...so as to keep the wage-labour market full for the colonists"

(Marx. Capital)

Some history

- There were large numbers of deaths from infectious diseases among the indigenous people when the Pacific was colonised in the 19th century
- However, some populations experienced very few deaths
- The main determinant of death from infectious disease was whether land was taken

History

"What was distinctive about the British colonies of settlement was the attempt to create 'little Englands' in new lands…by physically transplanting a vertical slice of British society"

(Bedggood. Rich and poor in New Zealand)

History

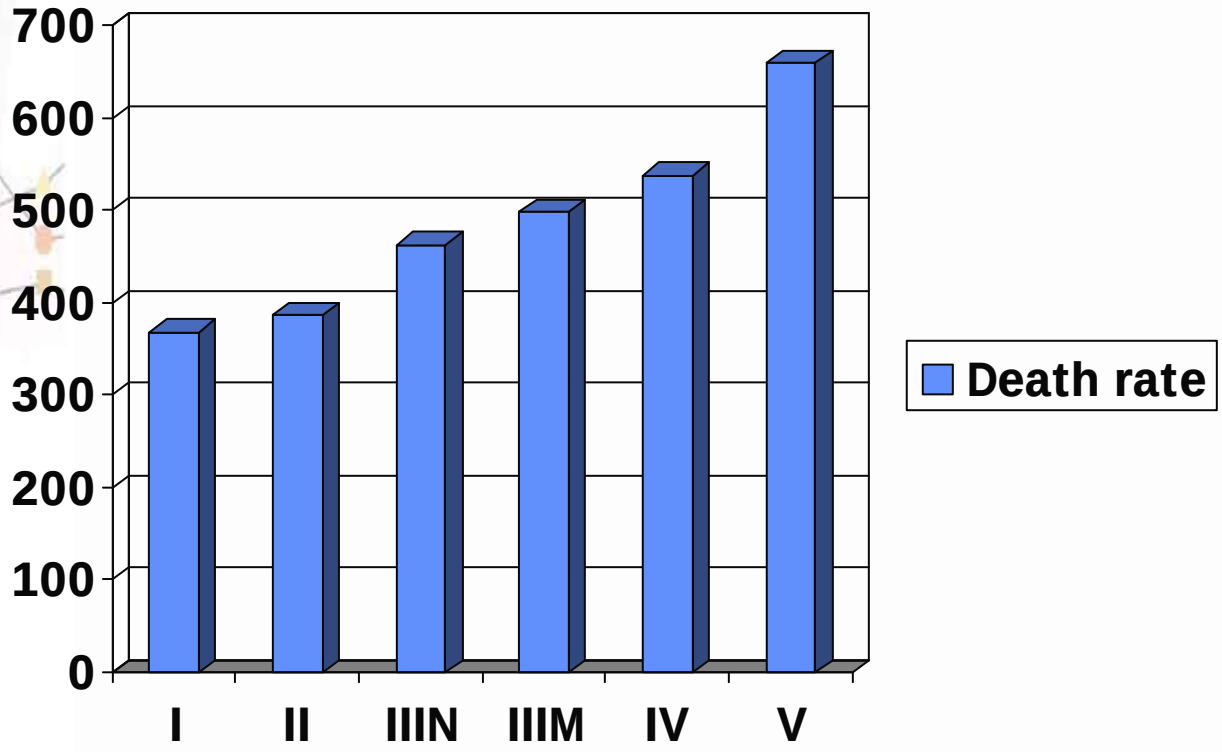
"New Zealand's fortune was Britain's fortune. Refrigeration, climate, and Britain's place in the world…made New Zealand a specialised colony, profitable to Britain…it dominated New Zealand through its control of shipping, finance, insurance, handling and selling of products"

(Sutch. Poverty and progress)

Historical myths and legacies

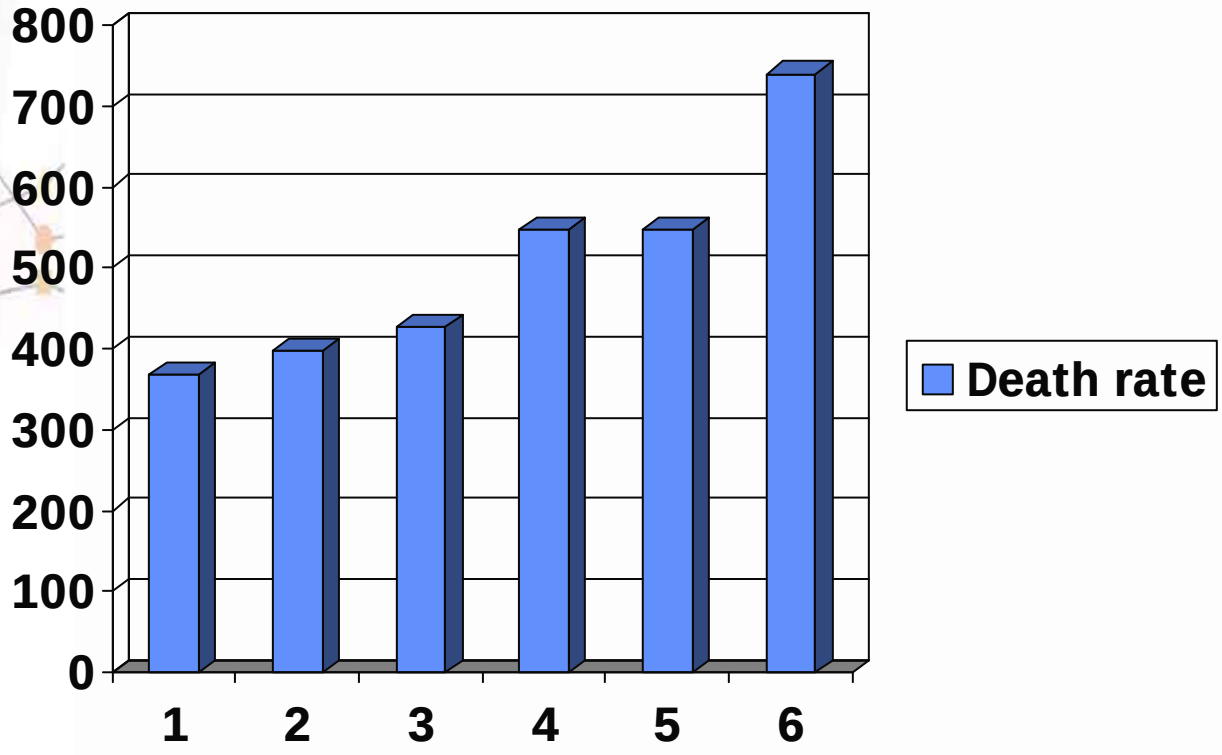
- Widespread belief that New Zealand was a “classless” society, or at least did not have the same rigid class system as the UK
- Belief that New Zealand was “created” in 1840 and has remained essentially the same ever since
- A “pioneer society” with an emphasis on practical matters and little time for history, theory or philosophy
- Maori were both separate from, and part of, the imported economic system
- Subsequent migrants (e.g. Chinese, Pacific) were also both separate from, and part of, the system

Social class differences in mortality in men aged 15-64 in the UK 1970-1972.



Social class differences in mortality in men aged 15-64 in NZ 1974-1978.

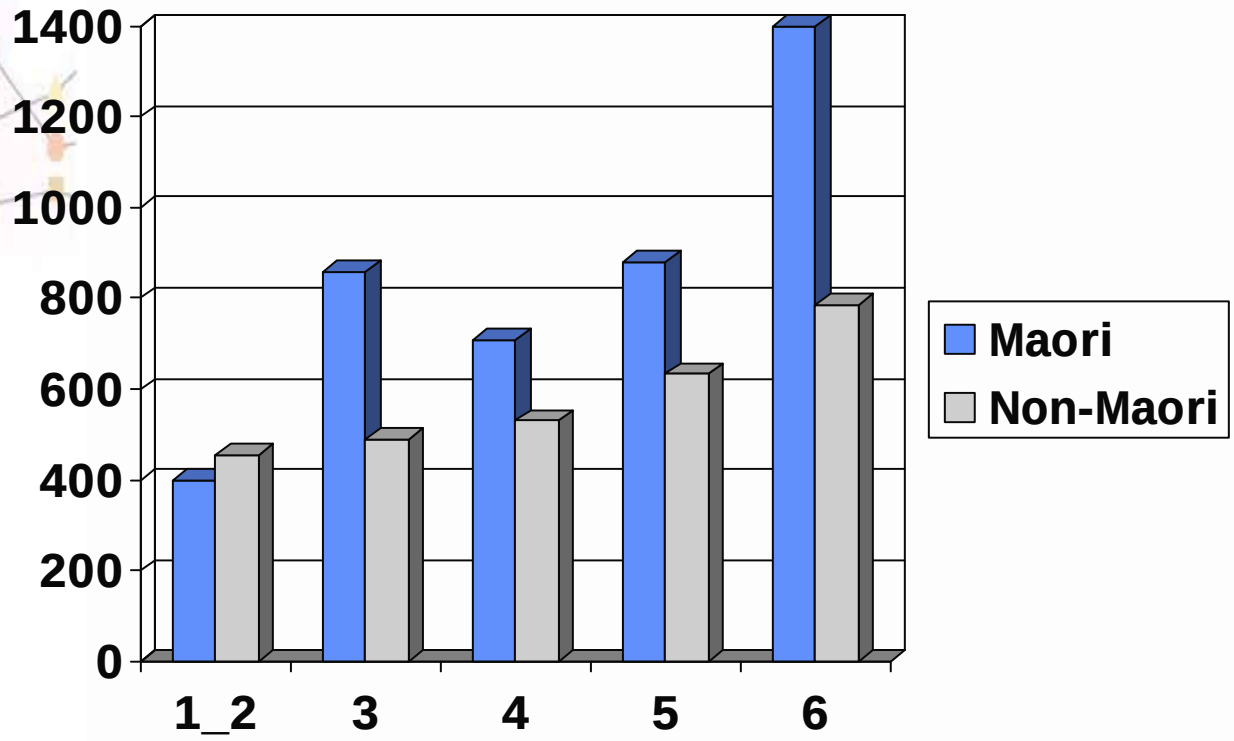
(Pearce et al. NZ Med J 1983; 96: 281-5)



Determinants of differences in mortality between Maori and non-Maori aged 15-64

(Smith and Pearce. NZ Med J 1984; 97: 101-8)

Only about 20% of the excess Maori mortality was due to social class (as defined by occupation)



Determinants of differences in mortality between Maori and non-Maori aged 15-64

(Smith and Pearce. NZ Med J 1984; 97: 101-8)

- Maori/non-Maori differences showed different patterns than SES differences
- Most of the SES differences were due to “environmental” factors such as smoking and car accidents
- Nearly one-half of the Maori/non-Maori differences were due to deaths from causes which could be prevented by good access to health services. These included rheumatic heart disease, nephritis, bronchiectasis, diabetes, asthma, gout and tuberculosis

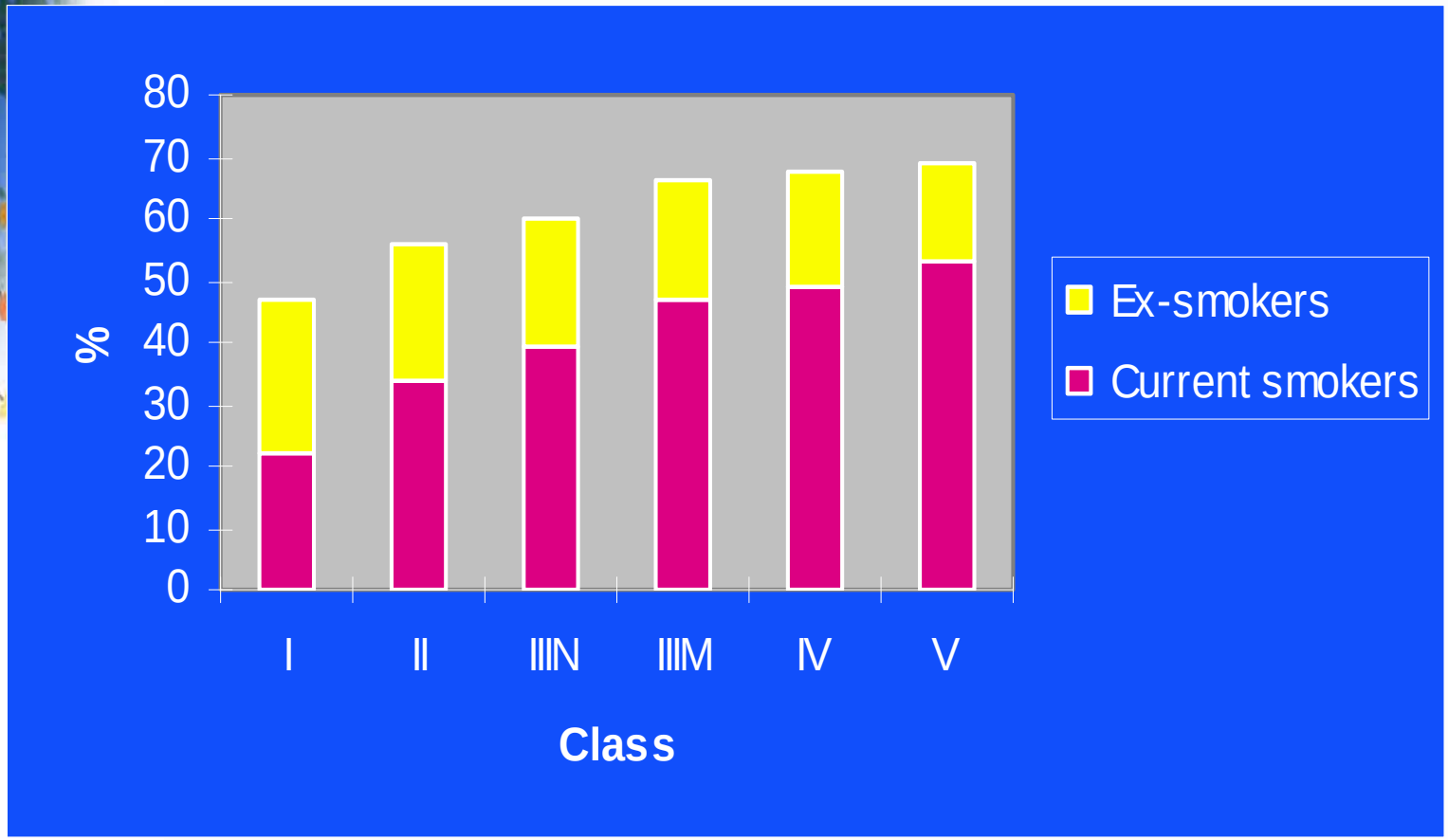
The “lifestyle” approach

- Focus on individuals, health is an individual responsibility
- Little consideration of the socioeconomic context
- Interventions to persuade individuals (or communities) to change their lifestyles

Problems of the "lifestyle" approach

- Many intervention studies have been conducted, at both the individual and the community levels, but the results have generally been disappointing
- The decline in heart disease has been no greater in communities which have experienced specific health promotion interventions than in those that have not
- Health promotion through the health services is particularly difficult in New Zealand because of the way that primary care is organised

Problems of the “lifestyle” approach: Smoking in NZ 1976 census



Problems of the "lifestyle" approach

- Tends to move the problem from the rich to the poor and from rich countries to poor countries
- Danger of "blaming the victim" for not being willing to follow our advice and change their lifestyle
- Is useful when it is done as part of a wider population strategy (e.g. anti-smoking legislation, Maori development)

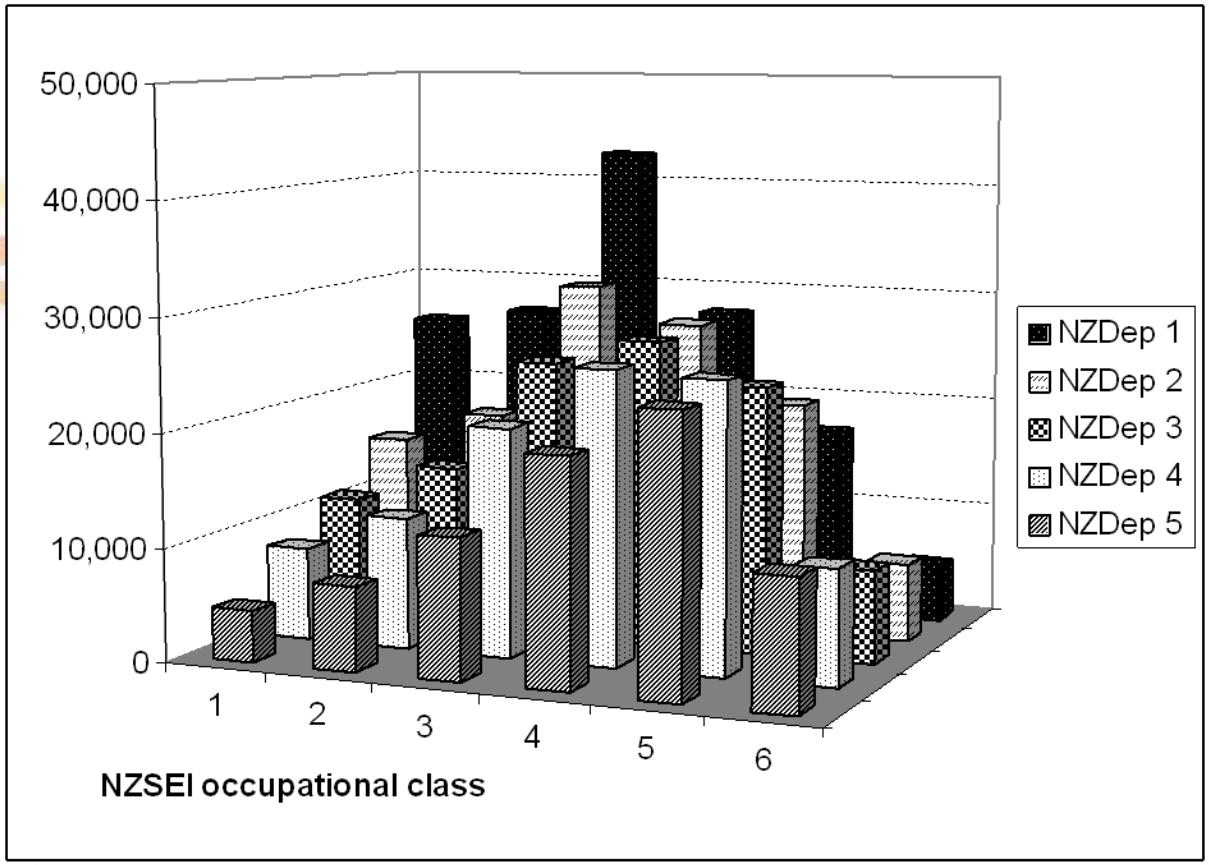
The “community” approach

- Focus on geographically-defined communities
- Little consideration of the macro-level socioeconomic context
- Identification of the most “deprived” communities (e.g. using NZDep because this is easily measurable)
- Interventions in communities, e.g. to increase levels of social capital

Problems of the “community” approach

- It is unlikely that improvements in “social capital” in isolation will lead to significant improvements in health
- Unless the overall amount of inequality within society is also reduced, the community approach tends to just move the problem between geographical communities
- Some communities do very well, and some fall “into the gap”
- Most deprived people don’t live in deprived communities

NZSEI occupational class varies within NZDep and vice versa



Problems of the “community” approach

- People live in “communities”, but they are not geographically-defined
- Danger of “blaming the victim” at the community level
- Is useful when it is done as part of a wider population strategy

The Black Report

- Reviewed evidence on socioeconomic differences in health
- Discussed possible explanations for these differences
- Produced (and costed) policy recommendations to reduce these differences
- “The surest way to alleviate the effects of poverty must be to alleviate poverty itself”

(DHSS, 1980; Black, 1993)

The Black Report

"We have tried to confine ourselves to matters which are practicable now, in political, economic and administrative terms, and which will…exert a long-term structural effect…*Above all the abolition of child poverty should be adopted as a national goal*"

(DHSS, 1980)

The Black Report

Recommendation	1996 prices (m)
• Free milk for under 5s	700
• Expansion of day care for under 5s	1,250
• Special programmes in 10 areas	50
• Child benefit increased	2,200
• Age-related child benefit	2,900
• Maternity grant increased	140
• Infant care allowance	1,000
• Free school meals	1,460
• Comprehensive disablement allowance	2,700
Total annual cost	12,500
(as % GDP)	1.7
(as % social security)	11.7

Implications for health policy

1. Do we need a New Zealand version of the Black report?

   - Has this already been covered, or do we need a report that will make firm policy recommendations?

   - If we do need one, who should fund it?

   - Would we need one report or two (I.e. Maori/non-Maori)?

Socioeconomic factors and health

"As part of health impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their effect on health inequalities"

(Acheson, 2001)

Implications for health policy

2. How can we influence the policies of other Government Departments?

- Intersectoral collaboration is difficult and often ineffective

- Do we need Health Impact Assessments to monitor and influence the policy of government Departments?

- Who should do them?

Implications for health policy

3. What can we do within the health services?

- Should strategies be national or area-based?

- If we are to do interventions in particular communities (either as part of a national strategy or as independent interventions) then how should these communities be defined?

- What sort of interventions should be done (e.g. material circumstances, social capital?)