

# **“The Evidence of Inequality: Health Promotion Challenges”**

**Ethics and Evidence in Health Promotion - Health Promotion  
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# Outline

- The right to health
- The evidence of inequality - Māori health status
- 6 challenges for Health Promotion
  1. Acknowledge the need to intervene at socio-economic determinants level
  2. Debunk the myths
  3. Critique our own role in producing ethnic health inequalities
  4. Reject victim-blame analyses
  5. Understand needs v.s. rights
  6. Eliminate inequalities by prioritising Māori
- IHD as an example

# The Right to Health

The Right to Health includes:

- The right to health care
- The right to healthy conditions

Yamin 2005:Am J Pub Health. 95:1156-1161



Key conventions/treaties about rights:

- Universal Declaration of Human Rights (1948)
- International Covenants on:
  - Civil and Political Rights
  - Economic, Social and Cultural Rights
- United Nations Draft Declaration on the Rights of Indigenous Peoples
- Treaty of Waitangi

# The Right to Health

- Good health is a fundamental human right
- States are accountable to ensure rights are met via
  - health system, and
  - determinants of health
- Ethnic disparities in health are a breach of human rights

# The State of Māori Health in NZ

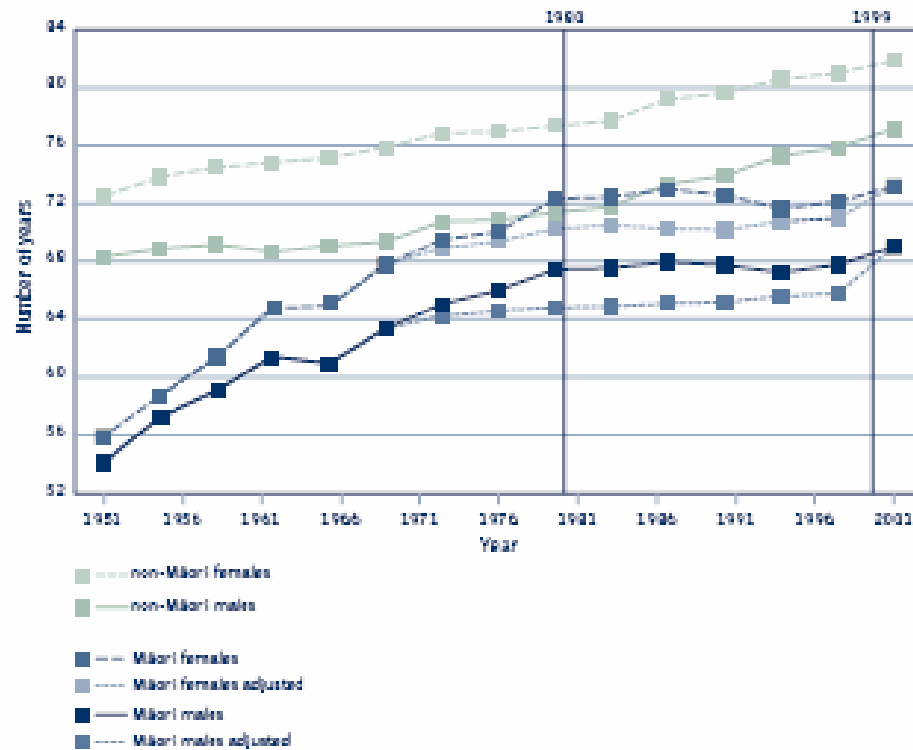
Māori health is characterised by systematic disparities in:

- health outcomes
- exposure to the determinants of health
- health system responsiveness

# Māori health status

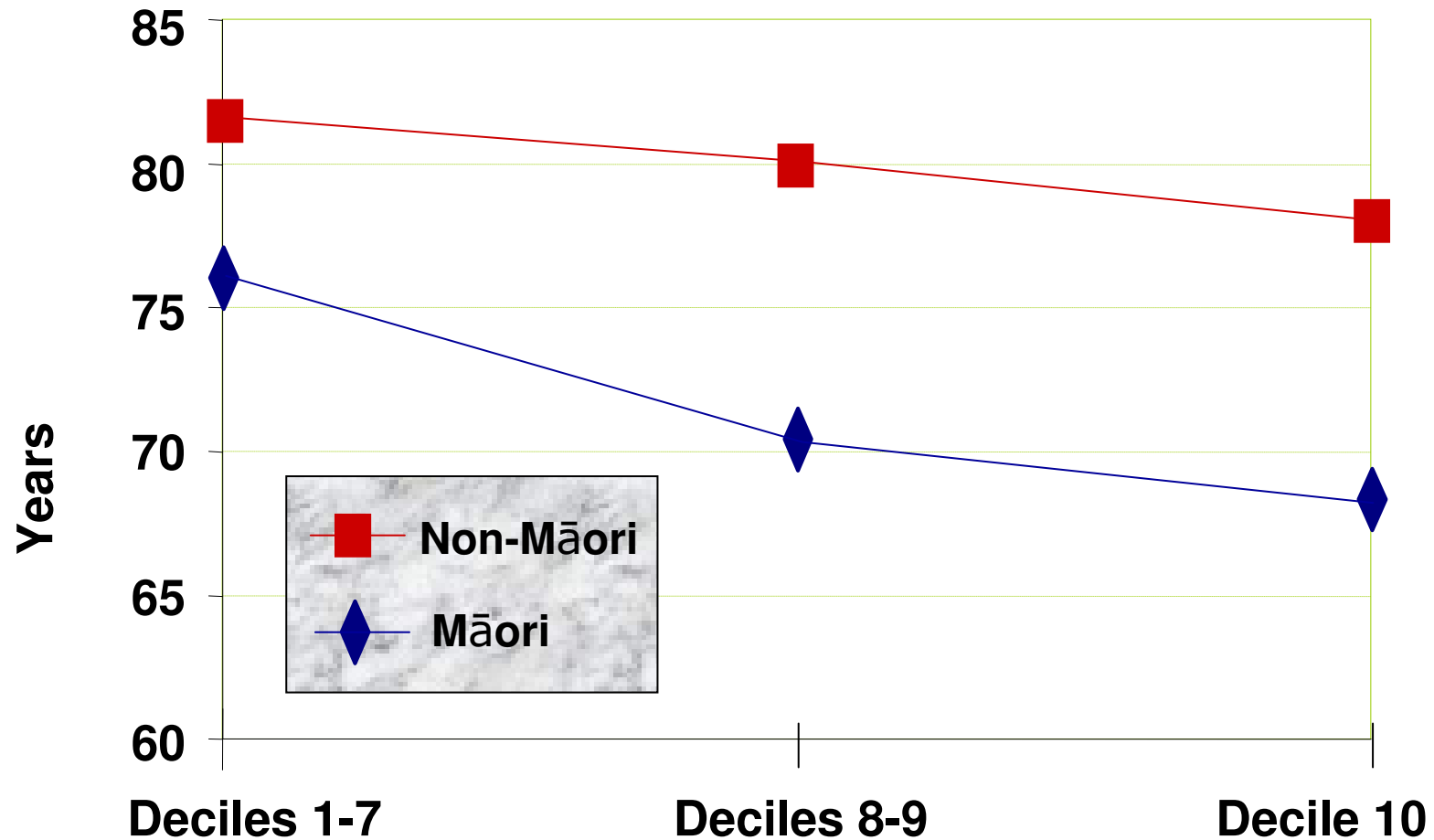
## Life expectancy

Figure 4: Life expectancy at birth, by gender and ethnicity, 1951–2001



Note: Adjusted life expectancy period  
 Source: Jaqui et al 2009; Statistics New Zealand

## Life expectancies at Birth, 1995-97 for Females by Deprivation Group and Ethnic Group (Reid, Robson, Jones 2000)



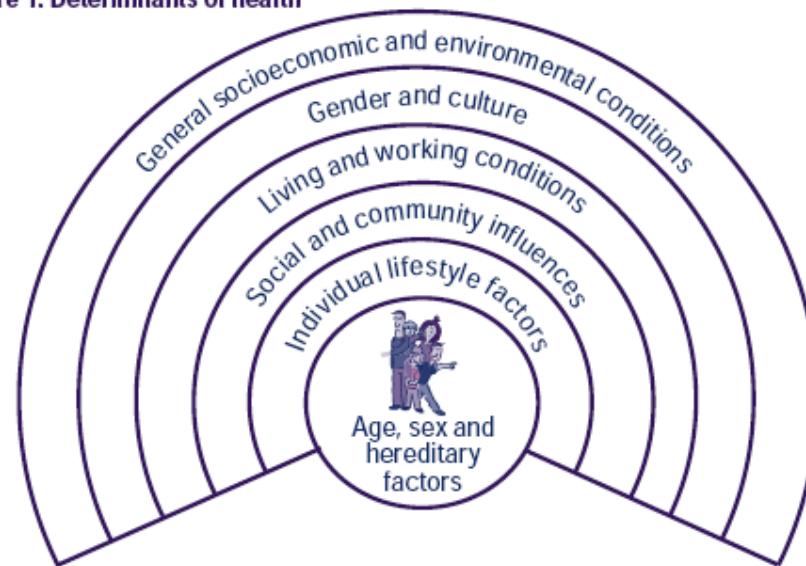
# 6 challenges to meet Māori rights to health

- Inequalities in health for Māori are the major health challenge for NZ...
- Challenges for health promotion
  1. Acknowledge the need to intervene at socio-economic determinants level
  2. Debunk the myths
  3. Critique our own role in producing ethnic health inequalities
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  6. Eliminate inequalities by prioritising Māori



# 1. Acknowledge the need to intervene at socio-economic determinants level

Figure 1: Determinants of health



Source: adapted from Dahlgren and Whitehead (1991)

Source: MoH (2002). Reducing Inequalities in Health.

<http://www.moh.govt.nz>. Reducing Inequalities in Health.

Dahlgren G, Whitehead M. 1991. *Policies and Strategies to Promote Equity in Health*. Copenhagen: World Health Organization Regional Office for Europe.

# Determinants of Health Model

Relatively changeable

Figure 1: Determinants of health

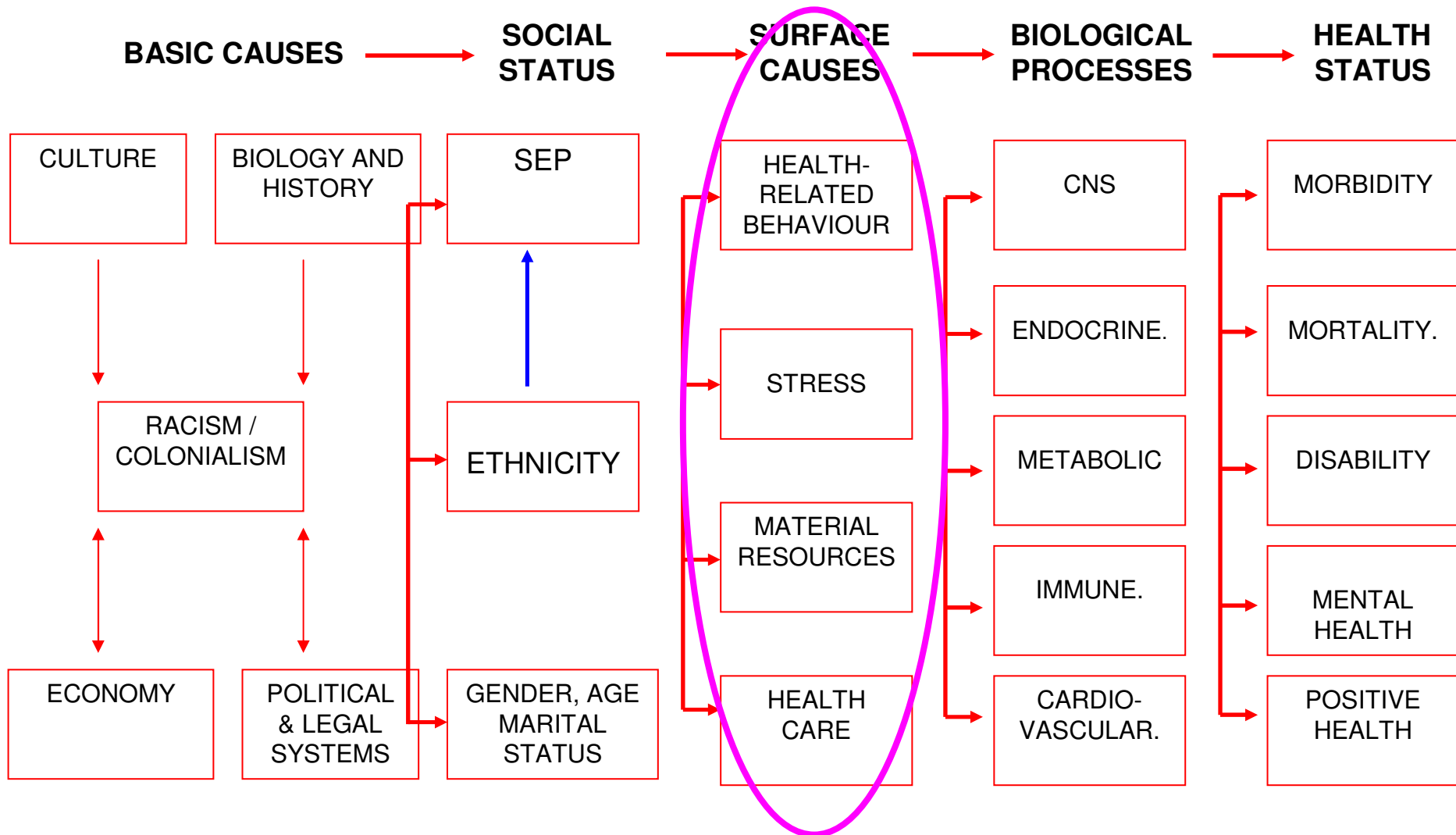


Source: adapted from Dahlgren and Whitehead (1991)

Relatively unchangeable

- Age, sex hereditary factors relatively unchangeable
- Changeable factors:
  - Individual lifestyle
  - Social and community influences
  - Living and working conditions
  - Socioeconomic and environmental conditions

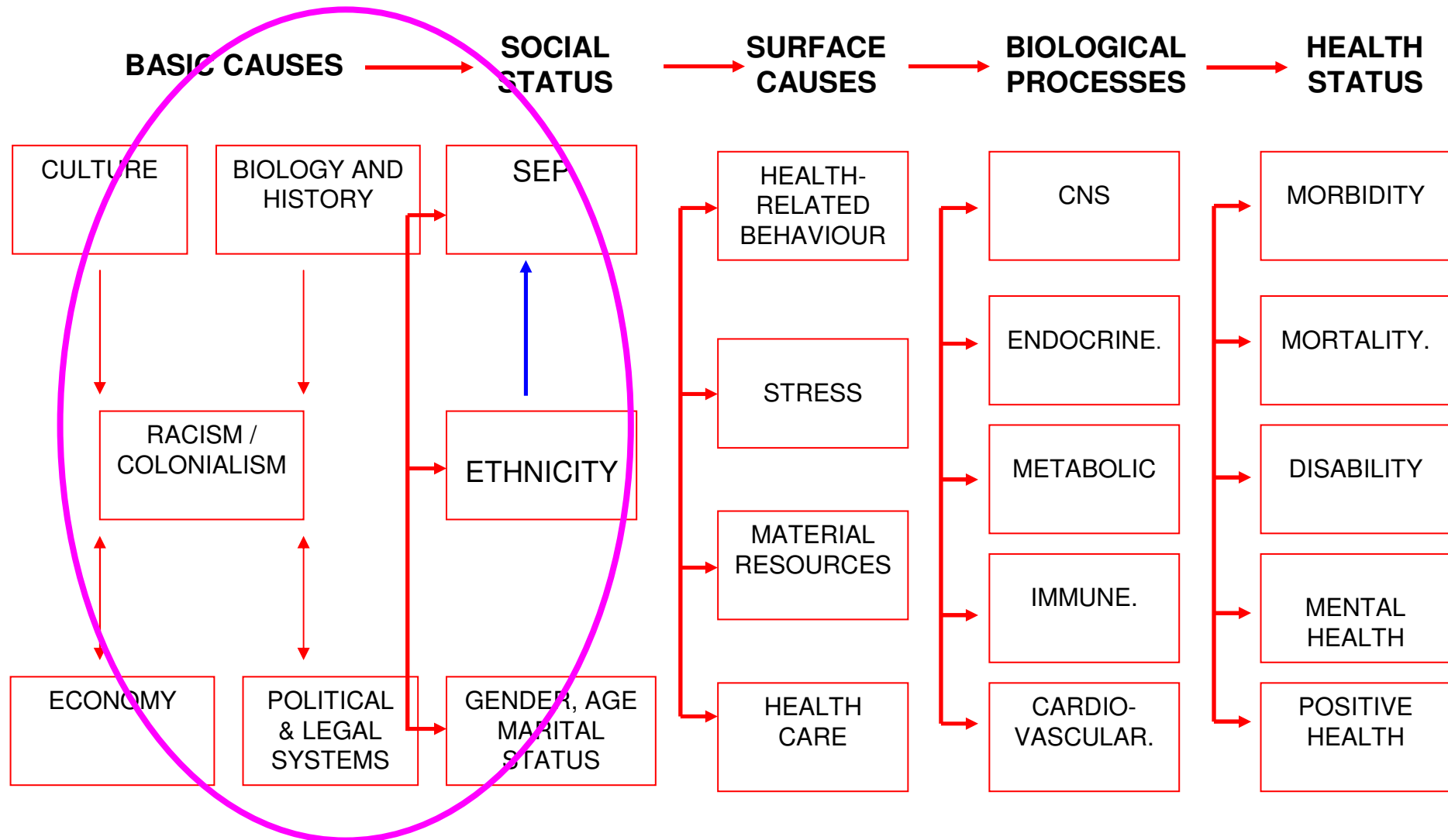
# Williams Model:



## Intervene at **SE** determinants level

- Think beyond lifestyle/behavioural interventions to improve health
- Acknowledge basic causes of inequalities e.g. economical/political/racism....
- Embrace the complexity!

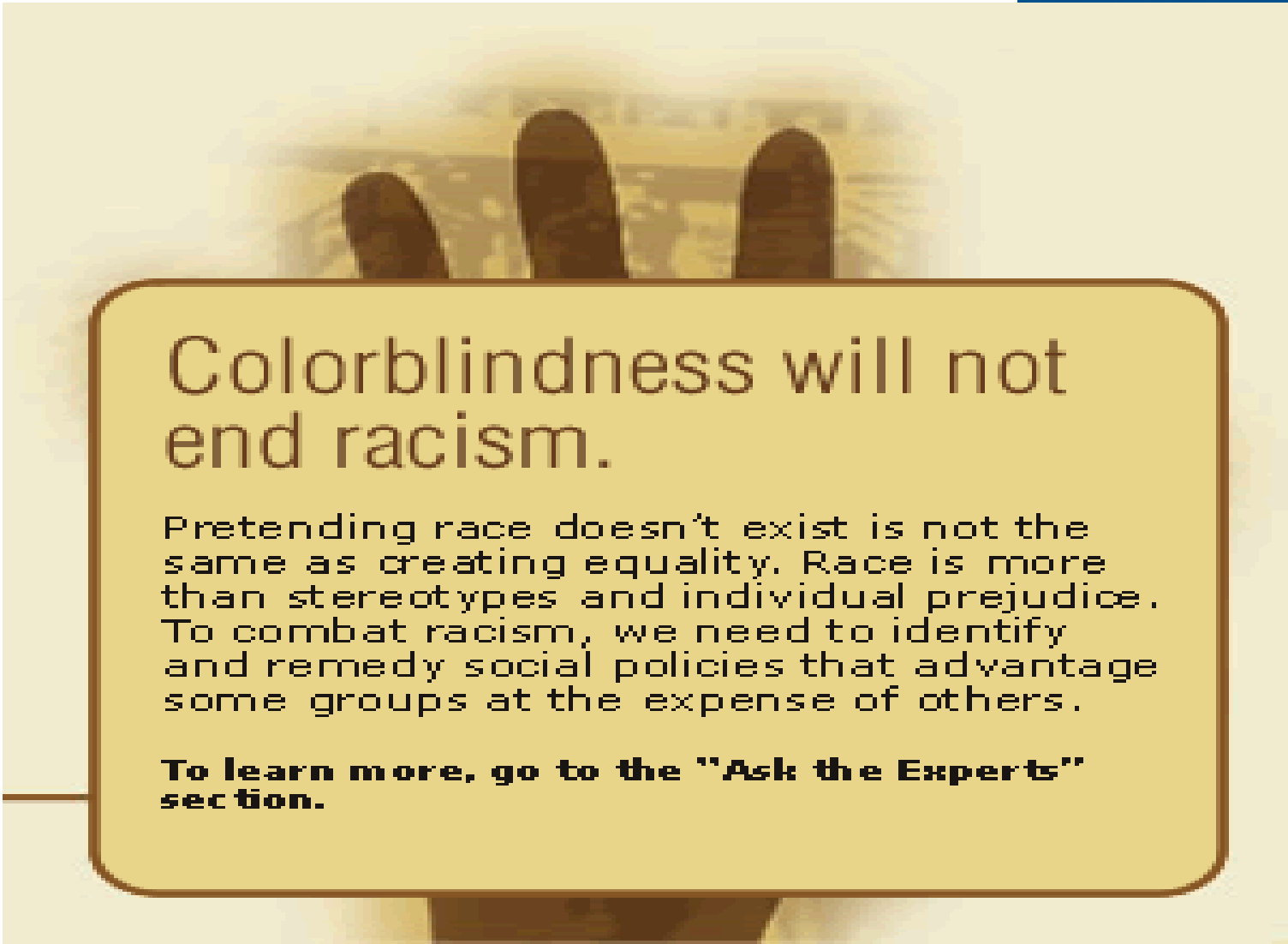
# Williams Model



## 2. Help debunk the myths

- “Everyone’s equal”
- “We’re all New Zealanders”
- Māori-specific interventions are ‘racist’
- Māori are being ‘privileged’

Ethnicity is not the same as Nationality  
EQUALITY (doing the same) versus EQUITY  
(doing what is fair/just)

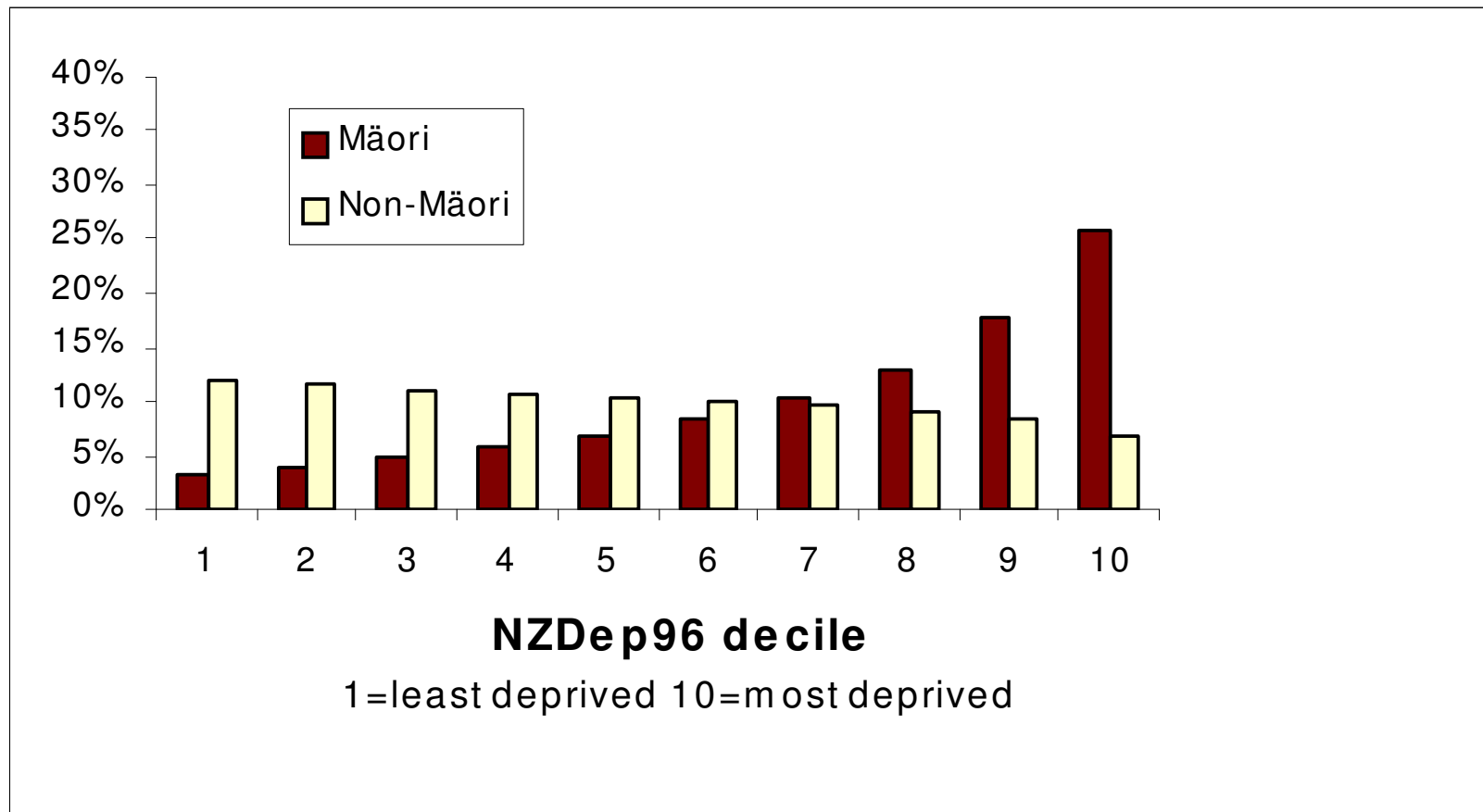


Colorblindness will not  
end racism.

Pretending race doesn't exist is not the same as creating equality. Race is more than stereotypes and individual prejudice. To combat racism, we need to identify and remedy social policies that advantage some groups at the expense of others.

**To learn more, go to the "Ask the Experts" section.**

# Whose being privileged in deprivation?





# Income Support?

- Pākehā are more likely to receive:
  - Disability Allowance (Howell & Hackwell, 2003)
  - Special Benefit (Hackwell & Howell, 2002)
  - Grants rather than loans.

# Housing?

- Discrimination in private rental and real estate market exists

Macdonald 1986, Knight 1991

- Housing policy - impact increased rather than mitigated disparities
  - commercialisation, market rentals, reduced housing stock, Māori housing loans stopped, etc.

## **(in)Justice?**

- Pākehā adolescents will have lower levels of police scrutiny
- Even when Pākehā offend at the same frequency, they have half the police contact, experience fewer arrests and receive fewer convictions

Fergusson et al 2003

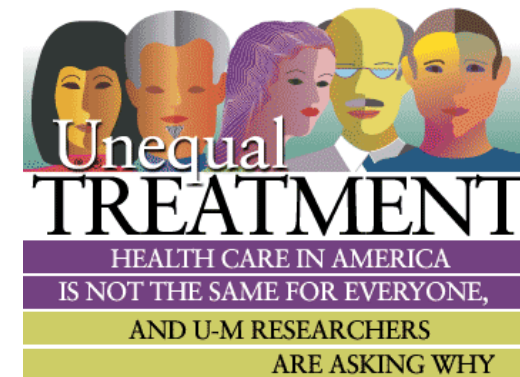
### **3. Critique our own role in producing ethnic health inequalities**

- “even well intentioned whites who are not overtly biased and who do not believe they are prejudiced typically demonstrate unconscious implicit negative racial attitudes and stereotypes”

Institute of Medicine, 2002

# Unequal Treatment: 2002

- Ethnic inequalities exist
- Clinical encounter important
- Provider
  - Bias/prejudice against minorities
  - Greater clinical uncertainty
  - Beliefs or stereotypes about behaviour of minorities
- Patients
  - Might react to provider's behaviour
  - Mistrust/refusal



# New Zealand health system

- Differential access to and through services
  - Unmet need in primary care (NZHS 02/03)
  - Screening (IMG monitoring reports)
  - Cancer services (Robson et al. 2006)
- Differential quality of care
  - **In-Hospital Care** – Davis et al, 2006. Māori patients nearly 50% more likely than non-Māori to suffer adverse events in hospital, after controlling for age, sociodemographics and case-mix.
  - **Getting surgery** Seddon et al 2006. Despite higher CPAC scores for Māori and Pacific men, these did not translate to greater urgency in clinical priority.
  - **General practitioners.** McCreanor & Nairn 2002 Doctor's talk about Māori (reflecting stereotypes)

## 4. Reject victim-blame analyses



- Been there with smoking...



- Heading there with obesity...

## 5. Understand needs v.s. rights

- Addressing Māori:non-Māori inequalities reflects high need AND Māori rights...
- Māori have high need because of the breach of rights
- Address Māori issues because Māori are indigenous to Aotearoa New Zealand
- Doesn't matter what number or % Māori are....

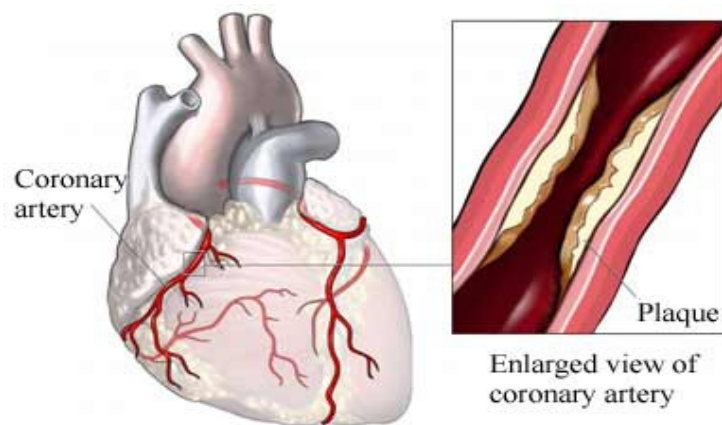


## 6. Eliminate Inequalities by..

- Prioritising Māori
- Taking an Equity not Equality approach
- Acknowledging who is being privileged in society



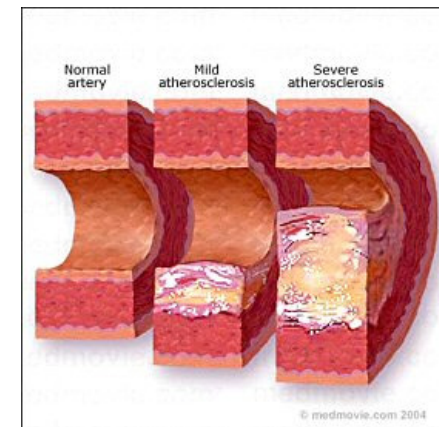
# Ischaemic Heart Disease - What is it?



- Arteries that supply blood to the heart become blocked or narrowed
- Lack of oxygen results in damage to the heart muscle

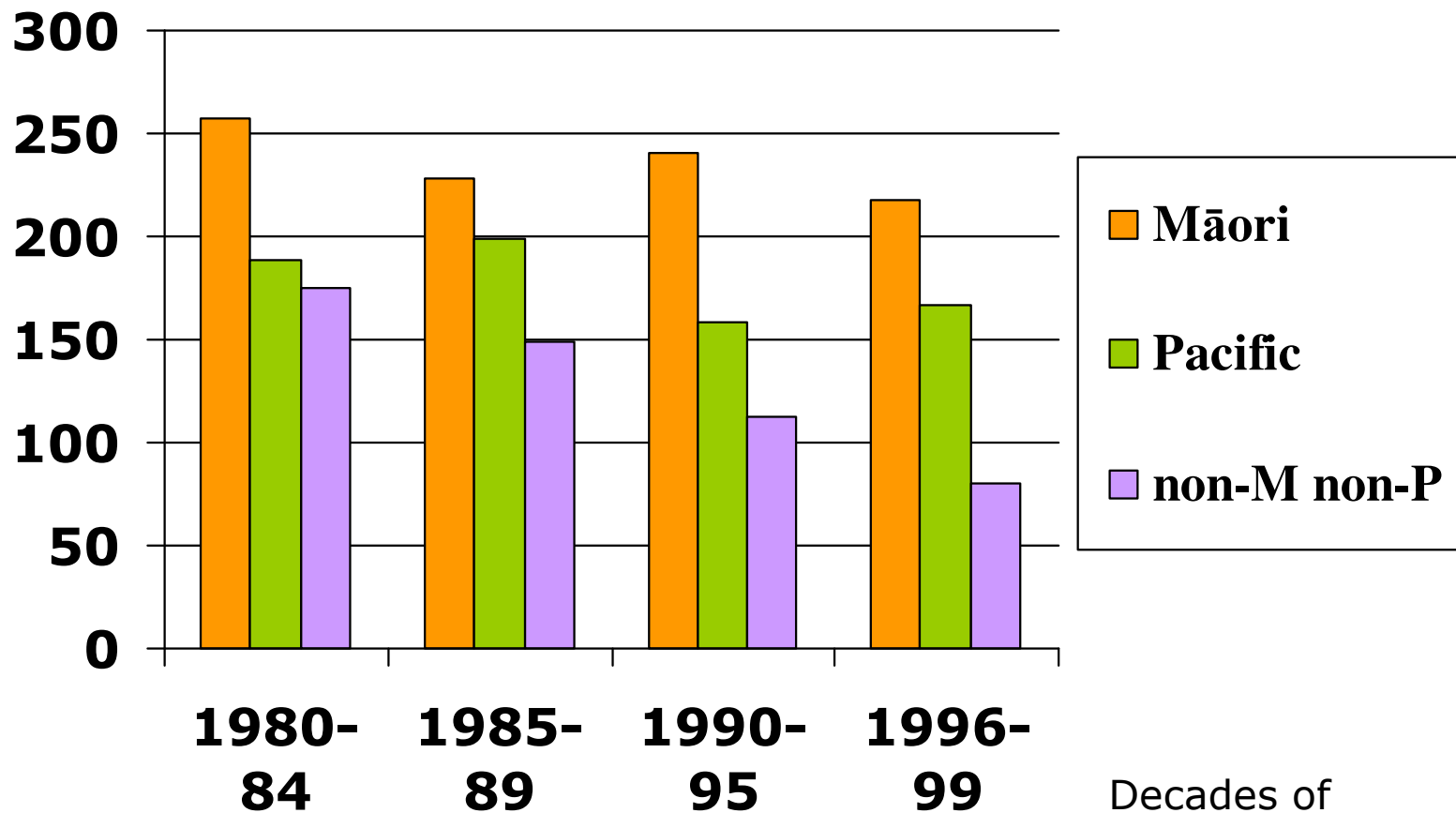


- High blood cholesterol,
- Smoking
- High blood pressure
- Diabetes
- Obesity
- Not being physically active



# IHD Mortality Males

age-standardised rates per 100,000 (ages 1-74 years)



Decades of Disparity, 2003.

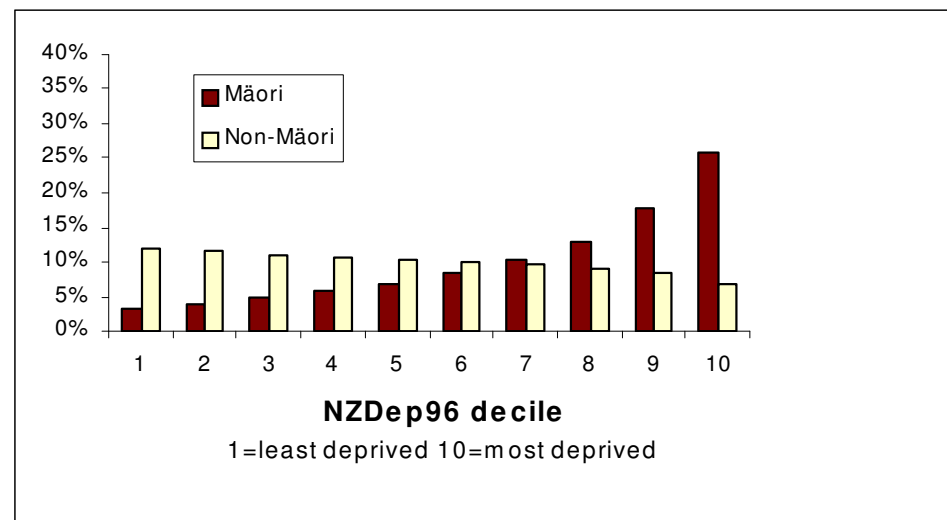
# What is the 'predominant' Health Promotion response?

- Tell the individual (Māori) to:
  - Stop smoking
  - Eat better
  - Exercise
  - Lose weight
  - Treat diabetes
  - Lower cholesterol

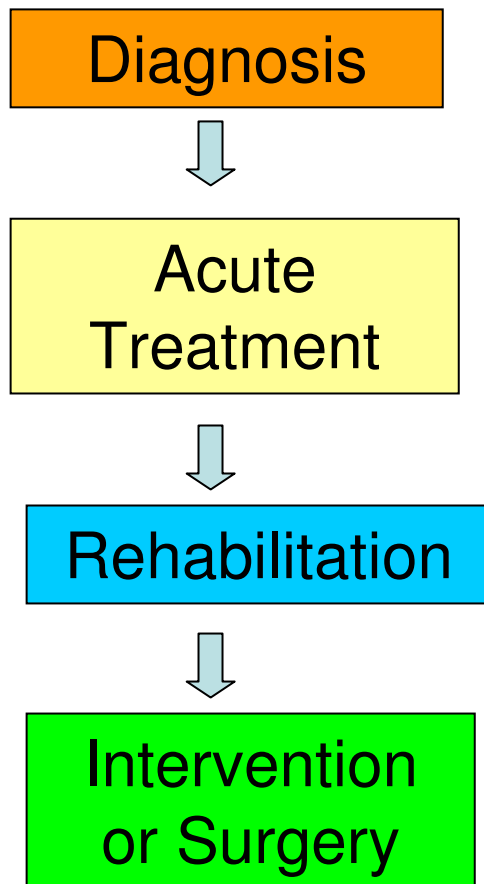


# Problems with 'predominant' health promotion focus for IHD

- Risk factors highly correlated with SEP.
- Does not acknowledge the need to intervene at socio-economic determinants level.
  - Reduce distribution of risk factors, address racism etc.

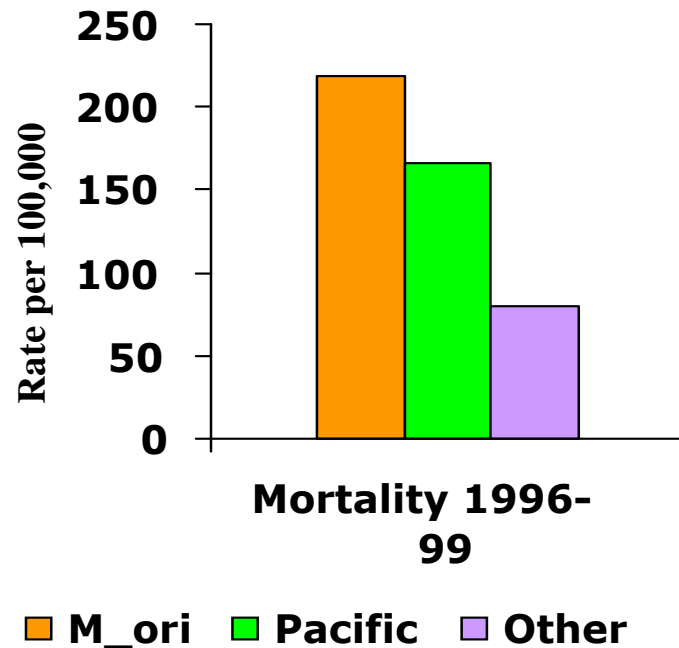


# Problems with 'predominant' health promotion focus for IHD



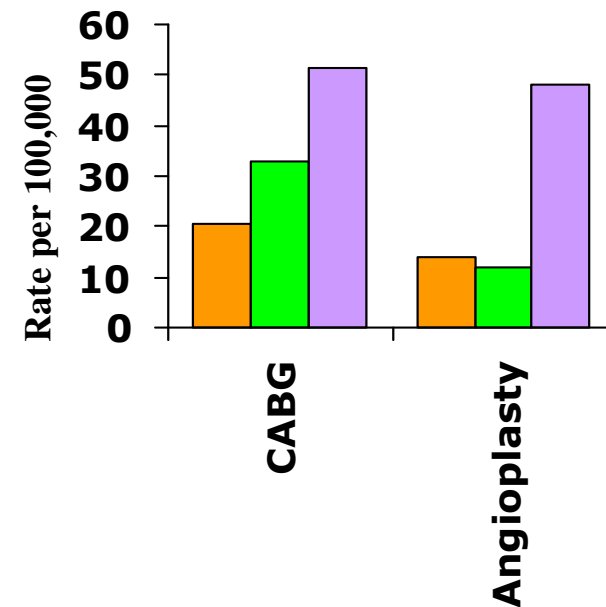
- Not everyone is receiving equity in IHD care...
- Ethnic inequalities exist along care pathway

## Mortality rates males 1996-1999



Ajwani et al 2003

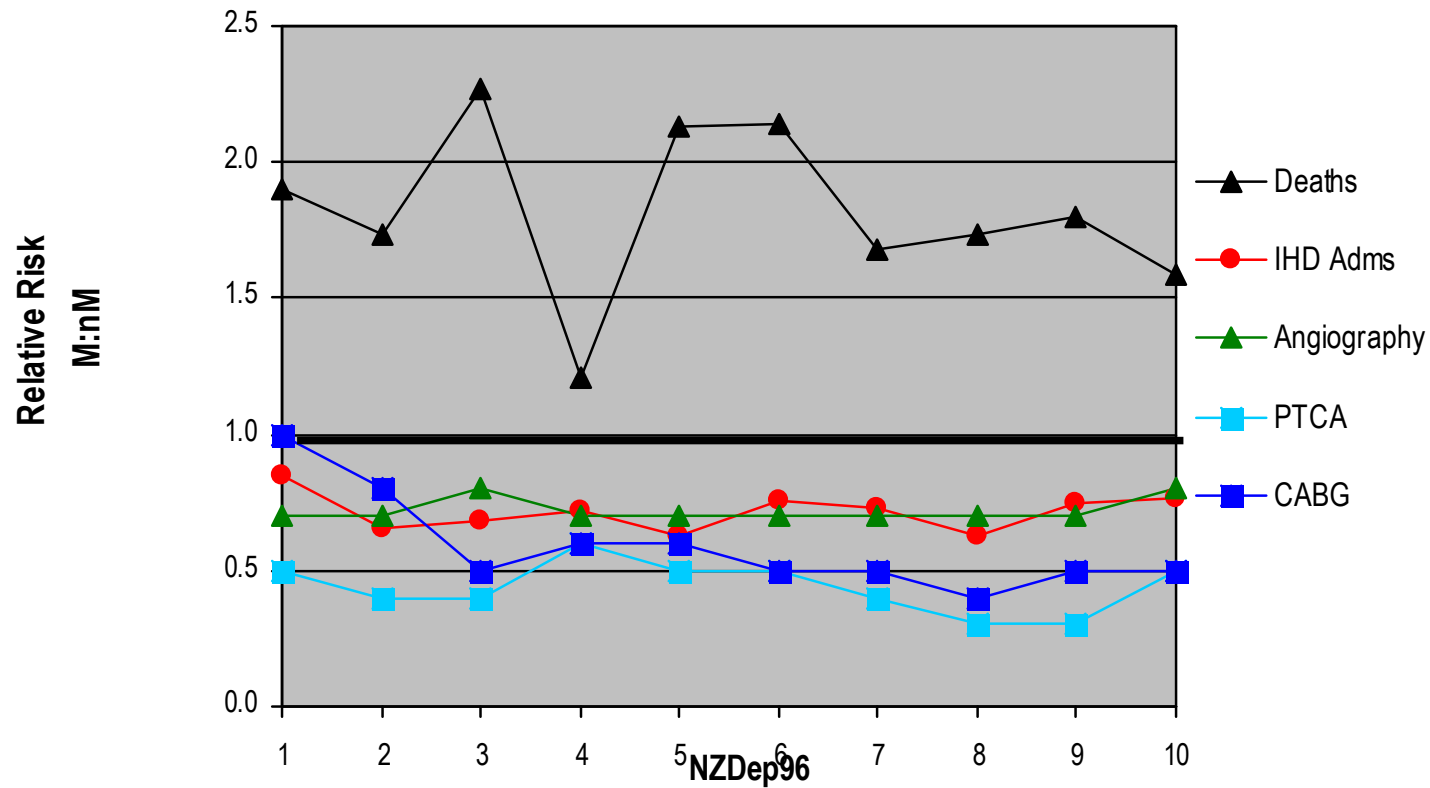
## Procedure rates males 1990-1999



Tukuitonga & Bindman 2002

# Results Summary - Males

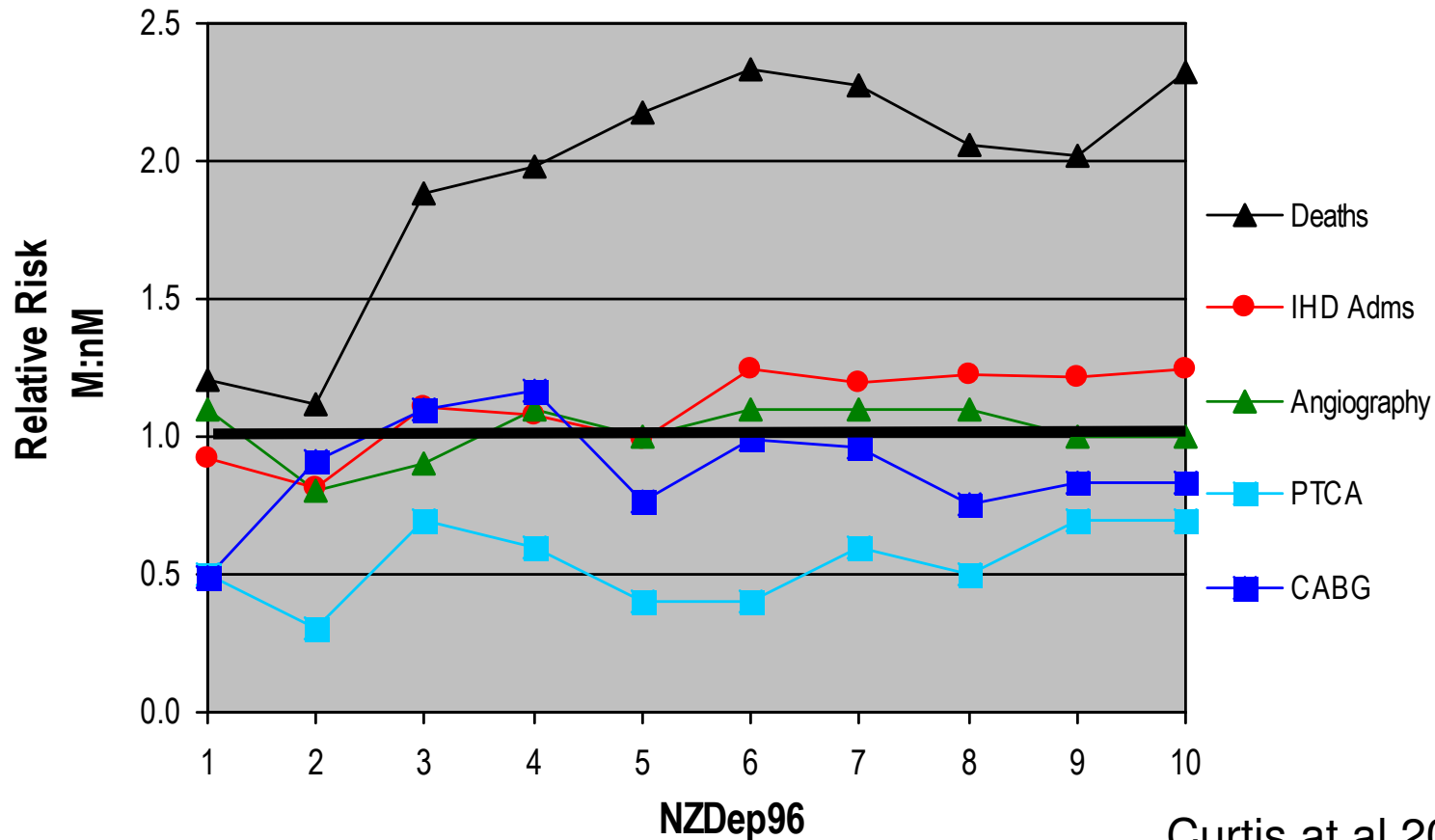
Age standardised male relative risk of IHD death (1996-1999) and IHD admission, angiography, PTCA and CABG (1988-2001) by deprivation decile.





# Results Summary - Females

Age standardised female relative risk of IHD death (1996-1999) and IHD admission, angiography, PTCA and CABG (1988-2001) by deprivation decile.



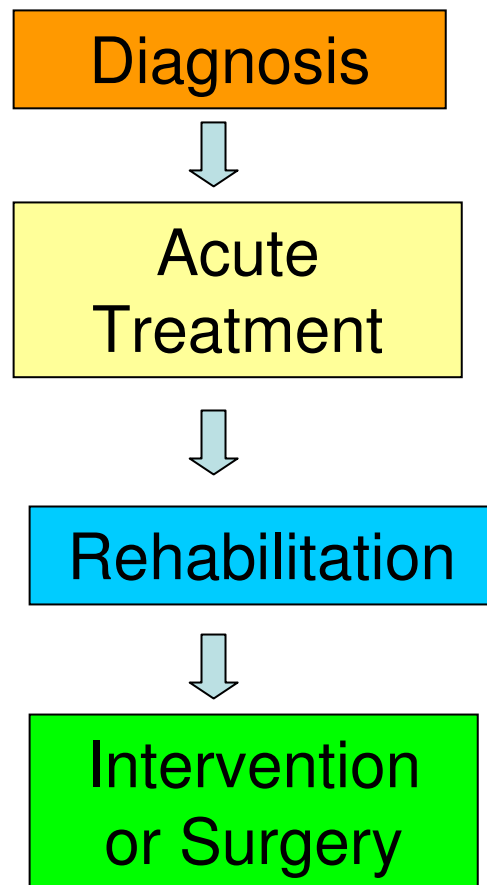
Curtis at al 2004

# Cardiac Rehabilitation

- A national audit in 2002 found deprivation and lack of transport were associated with reduced likelihood of referral to and attendance at cardiac rehabilitation programmes (Doolan-Noble et al 2004).



# Problems with 'predominant' health promotion focus for IHD



- How ethical is it for HP to have a predominant life style risk factor reduction focus when there is EVIDENCE of inequalities elsewhere?
- Remember Ottawa Charter supports "reorientation of health services" ...
- What other health promotion interventions can/should be put in place?

## In summary..

- Health is a right!
- Evidence of inequalities in health status for Māori
  - unjust, unfair and unacceptable
- 6 challenges for Health Promotion
  1. Acknowledge the need to intervene at socio-economic determinants level
  2. Debunk the myths
  3. Critique our own role in producing ethnic health inequalities
  4. Reject victim-blame analyses
  5. Understand needs v.s. rights
  6. Eliminate inequalities by prioritising Māori
- IHD is an example where challenges exist for health promotion...
  - Unethical not to change HP focus!