8. STRIKING A BETTER BALANCE PAPER: A HEALTH FUNDING RESPONSE TO REDUCING INEQUALITIES IN HEALTH

Officer responsible Jonathan Fletcher	**Author** Mary Richardson
Corporate Plan Output: Policy Advice	

The purpose of this report is to inform the Committee of a paper by the Health Funding Authority called Striking a Better Balance: A Health Funding Response to Reducing Inequalities in Health.

INTRODUCTION

This report attempts to provide a brief summary of a paper produced by the Health Funding Authority. The paper represents a response to the New Zealand Health Strategy, offering detailed objectives and draft work programmes to reduce inequalities by addressing wider determinants of health. It aims to inform further development of the NZ Health Strategy and the District Health Boards as they develop their policy and funding role.

The paper is of particular interest to the Council as it identifies that the health sector must build formal and informal partnerships with local authorities work. It also promotes:

- Strong and active relationships between local authorities, central government and businesses
- The health sector working with local authorities to promote local planning and safe and sustainable physical environments
- The use of community development processes (a key activity of the Christchurch City Council)
- That local authorities should adopt a broad view of health while performing their roles in providing health and social services

The paper identifies that for a population health approach to be truly effective it will require endorsement by and support from other government agencies. This report proposes that the Committee review the paper and consider whether it wishes to endorse its approach.

SUMMARY OF THE PAPER

The paper proposes an approach to funding health and disability support services which aims to improve health and reduce inequalities in health experienced by Maori, Pacific peoples and other lower socio-economic groups.

The purpose of the paper is to recommend a sector-wide population health approach to:

- improving health and independence and
- to reducing inequalities in health and disability experienced by Maori, Pacific peoples and other lower socio-economic groups.

The paper recommends:

- a population health approach to reducing inequalities in health and independence by addressing the wider determinants of health
- a draft set of objectives and work programmes to reduce inequalities in health for further development
- a structure to further develop and implement this work.

The paper identifies that a population approach:

"*Seeks to reduce inequalities by addressing the wider social, economic and cultural determinants of health. This approach can be used across all sectors of health service planning and delivery, including personal health, public health, mental health and disability support services. It uses both targeted and universal approaches in health care delivery (Burden et al 2000:3).*"

This paper outlines a population health approach to:

1. Improve the overall health of New Zealanders – by continuing to fund services that address lifestyle and other factors which negatively affect health as well as to;
2. Reduce inequalities in health – by giving greater emphasis than in the past to addressing the wider social, cultural and economic factors that have a role to play in health; and
3. Close the gap – by ensuring that services are reoriented to benefit Maori and Pacific peoples.

HEALTH INEQUALITIES

The paper identifies that the recently released draft New Zealand Health Strategy lists first among its objectives for immediate action, the need to address the health disparities between Maori, Pacific peoples and other New Zealanders. It recognises the need to address the wider determining factors which have an impact on health:

"*There is little we can do to influence our hereditary predisposition. There are, however, other factors affecting our health and independence over which we can potentially have more control. The impact these factors have on our health can be affected by changing individual and/or societal behaviour (Burton et al 2000:5).*"

The paper identifies that a number of factors and conditions affect health and well-being:

- **age, sex and hereditary factors** - are key, but relatively unchangeable, contributors to our health
- **individual lifestyle factors** – for example, whether we smoke, exercise, how much alcohol we drink
- **social and community influences** – for example, whether we belong to strong social networks, feel valued and empowered to participate in decision-making that affects our health and well-being
- **living and working conditions** – for example, whether we live in safe housing and have decent working conditions

- **culture and gender** – for example, women are over-represented in lower-paid jobs
- **general socio-economic and environmental conditions** – for example, our position in society, including income, education and employment, that affects our ability to participate in decision-making

HEALTH TRENDS

The paper identifies that, over the past century, New Zealand's experience in the health sector has mirrored that of other western countries. Improving the delivery of health services has improved the length and quality of life for all of the population. It argues that tackling some of the individual lifestyle factors through health promotion programmes on, for example, smoking, drink driving, diet, exercise, has also had a significant impact in improving the overall health and longevity of New Zealanders.

- The average New Zealander can now expect to live considerably longer than he or she could have expected to 100 years ago.
- The increase in life expectancy has continued at a steady rate over the last 40 years.
- Since 1972, there has been a gain of just over 5 years in the life expectancy at birth of men and 4.5 years in women.

The paper identifies that, while the overall health status of New Zealanders has improved over the years, there has been less success in making sure that good health is shared equally across all groups. People with the lowest income and level of education consistently have poorer health than people in higher income and education brackets. And there is evidence that the gap is widening. The paper reports that:

- Life expectancy at birth varies significantly depending on socio-economic status. Males in the least deprived decile of NZ society can expect to live nine more years than males in the most deprived decile. The difference for females is six years.
- Cancer deaths due to smoking occur more than three times as often amongst New Zealand men in the lowest education and income bracket as those in the highest bracket.
- In the 1992/93 Household Health Survey, people with household incomes of less than $20,000 per year were more than three times as likely as people earning more than $30,000 a year to report their health as "not so good" or "poor".
- Socio-economically disadvantaged groups of the New Zealand population have a higher rate of disability than more advantaged groups.

HEALTH INEQUALITIES FOR MAORI

The paper argues that the case linking socio-economic disadvantage to poorer health is particularly marked in the statistics for Maori. It reports that:

- Maori now make up 15% of all people in New Zealand.
- At 11.4%, Maori make up the highest percentage of unemployed in New Zealand.
- 46% of Maori receive income support – the highest percentage for populations grouped by ethnicity in New Zealand.
- Only 13% of Maori earn more than $30,000 or more compared to the New Zealand average of 21.6%.

- Only 2.6% of Maori obtained a tertiary degree, compared to the New Zealand average of 8%.
- Maori men and women have the lowest life expectancy in New Zealand. The life expectancies at birth are 67 years for Maori men and 72 years for Maori women, almost 10 years less than non-Maori.
- The death rates for Maori for almost all major causes have continued to decrease.
- For Maori, there are continuing high rates of Sudden Infant Death Syndrome (amongst Maori infants), youth suicide (especially among Maori males), violence and motor vehicle crashes.
- Death rates in middle age (45-64 years) are as great amongst Maori women as non-Maori women.
- Admission rates to psychiatric hospitals are 40% higher for Maori than non-Maori and these have doubled since 1975.
- Maori disability rates are higher than non-Maori at all ages under 65 years. This is particularly significant for Maori children, who experience higher levels of chronic illness.
- At 41.4%, Maori have the highest percentage of people who smoke regularly. This compares to the New Zealand average of 21.9%.
- Lung cancer is the main cause of death for Maori. Other major causes of death for Maori include cancer and heart disease.

The report identifies that much of the relatively poor health status of Maori can be attributed to poorer socio-economic status. However, there are other factors that lead to a health gap between Maori and non-Maori that go beyond socio-economic status.

Even when deprivation is taken into account, Maori have worse health than non-Maori. There are cultural factors at play that selectively disadvantage Maori by affecting risk behaviours (such as smoking) and/or affecting uptake of, or access to, health services. Any approach to reducing the health gap must consider what it is about being Maori and their relative position in society that increases the chances of having poorer health or dying earlier than non-Maori (Burden et al 2000:11).

It argues that:

"*Strategies adopted to reduce the gap in health between Maori and non-Maori must not over-simplify the issue by only considering socio-economic impact, without also taking into account the experiences of Maori and the context of their lives (Burden et al 2000:11).*"

The paper also argues that while much of the health inequalities for Pacific people can be explained by their low socio-economic status. However, it also argues that strategies will need to take into account the experiences and cultural infrastructure of Pacific peoples.

The report argues that socio-economic determinants are key drivers determining health. It would be simplistic, however, to focus only on these factors when ethnicity can negatively or positively affect health outcomes.

The paper outlines the Public Health Operating Group approach to improving health and reducing inequalities (which it developed based on the National Health Committee report and a wide range of other literature and experience).

The nine objectives identified are:

1. Target critical and achievable areas as a first priority.
2. Demonstrate proactive and visionary leadership that promotes a broad view of health.
3. Fund effective, accessible and innovative health sector interventions.
4. Promote consideration of the impact on health of social and economic policies.
5. Fund effective population-based services and environmental measures.
6. Promote community development processes.
7. Build and maintain effective partnerships.
8. Build the capacity of Maori communities and providers.
9. Build the capacity of Pacific peoples' communities and providers.

An expanded description of these nine objectives is presented in Appendix One of the paper (attached to this report).

The paper then identified a number of recurring themes running across the objectives and has proposed seven work programmes. These are:

1. Initiating immediate action.
2. Promoting a population health approach within health and disability sector planning and funding.
3. Reorienting public health funding to have a greater emphasis on reducing inequalities.
4. Working with other sector agencies to reduce health inequalities.
5. Empowering the community to adopt local solutions to local problems.
6. Reorienting the health provider workforce to adopt a population health approach.
7. Working with other agencies at a local level to promote healthy social and physical.

Recommendation:

1. That the information be received.
2. That the Committee endorse the "Striking A Better Balance" paper and objectives proposed in the paper.

Chairman's Recommendation: For discussion.