

Health equity: what does it mean for child health?

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Abstract: The concept of ‘health equity’ has become increasingly central to discussions around social determinants of health, and the resultant disparities in health outcomes. It has particular pertinence to paediatric populations in New Zealand: some of our most alarming disparities relate to child health, and there is increasing recognition of the need to reduce these inequities. Effective ‘health equity’ approaches in child health demand that clinicians broaden their roles to become strong advocates for social justice: in order to achieve progress in this area, it is essential that child health is prioritised at our most fundamental policy levels.

“Health equity” is a relatively new paradigm, and a term increasingly embraced within public health discussion. Indeed, it has become central to national health dialogues: the New Zealand Medical Association (NZMA) released a seminal position statement on health equity in March of this year,¹ and it has become a concept acknowledged increasingly by our Ministry of Health and other key national policy-making bodies. Health equity has particular relevance to paediatric population health, which is a highly topical issue on the current national political agenda.

For the modern clinician, sound comprehension of ‘health equity’ requires a conceptual mindshift of sorts. Instead of focusing on factors immediately upstream of an adverse outcome (dietary choices and body weight, cigarette smoke exposure, and so on), health equity frameworks demand that we move to examine the *most* fundamental of social determinants when attempting to understand unequal health outcomes. What we should really be concerned with, a health equity argument suggests, is the *ultimate* basic and deep-seated inequitable distribution: that of the power and resources within our society.

Differences in this distribution are both systemic and avoidable, and are hence (from a basic human rights and social justice perspective) inherently unjust and unfair.² Health equity challenges clinicians to adopt roles beyond the traditional, narrow boundaries of the physician: “the health sector has a role in advocating for and actively encouraging intersectoral approaches to addressing the social determinants of health...the whole of society needs to be involved, along with the whole of government”.¹

Despite its significant challenges as both a conceptual construct and a practical goal, the advantages of striving for health equity are manifold. If we are able to successfully address the primordial social discrepancies in question, potential benefits abound. One perhaps thinks most immediately of those at the *bottom* of social gradients (the most materially deprived, the unemployed and the poorly-housed), but there is increasing social evidence that reductions in inequality indeed benefit *all* members of society in terms of longevity and general health.^{1,3}

Nowhere is the health equity concept more poignant and pertinent than in child health. Children are indeed the ultimate ‘victims’ of their social context: they have not yet

had the lifespan to make any detrimental health choices (this obviates them of the ‘personal choice’ argument sometimes used to explain poor health in members of our lower social classes – smoking and obesity are oft-quoted examples). In addition, children do not possess the resources or facilities to actively modify their social circumstance. Moreover, the area of child health also provides the most dramatic and startling examples of *evidence* for the health equity argument: when social resources are distributed unequally by class and race, child population health outcomes distribute along the same lines in a dramatic, and frighteningly-predictable, fashion.²

New Zealand, unfortunately, provides some of the world’s most vivid illustrative examples on this point: in fact, our child health inequalities should be cause for profound national shame. A recent (2007) report by the Child and Youth Epidemiology Service highlighted a broad range of areas with poor child health outcomes. Whilst the overall statistics were a worry in themselves, by far the *most* concerning feature was surely the significant socioeconomic and ethnic disparities observed within the outcomes across almost every health indicator.⁴ For example, the relative risk of dying from sudden infant death syndrome was 10.6 times higher for an infant in NZDep deciles 9–10 over deciles 1–2.⁵

Rheumatic fever, perhaps, provided some of the *most* startling statistics: the relative risk of being hospitalised for the disease was 28.7 times higher in children from deciles 9-10 when compared with those from deciles 1-2.⁵ Ethnic disparities were equally profound in this case: Pacific children had a relative risk 48.6 times higher, and Māori children 30 times higher, than their European counterparts.⁵

Experts have used statistics such as these to illustrate an increasingly-apparent argument: that social disparities themselves are intrinsically poisonous, and it is *relative* poverty (more so than absolute) that creates poor health outcomes.^{3,4} In a recent NZMJ article, Turner et al argue: “There is increasing evidence that ill-health and other social problems are linked to relative deprivation and income inequality rather than absolute levels of income...poorer countries than us have much better child health statistics. Appreciation of relative deprivation, rather than absolute, and the corrosive impact of increasing income inequality mean that we must all engage in the debate about our children’s future.”⁴

As further cause for alarm, New Zealand’s children are far more *heavily*-concentrated below the poverty line than any other segment of society: alarming data from the Ministry of Social Development’s 2008 Living Standards Report showed that 19% of New Zealand’s child population were living in significant or severe hardship (compared with just 13% of the total population, and 4% of those 65+).⁶ Maori and Pacific peoples had hardship rates two to three times those of European and other ethnicities, and solo parent and beneficiary families were also grossly over-represented.⁶

How, then, can the principle of health equity be applied to addressing these issues? At face value, the concept can begin to seem somewhat depressing: if the origins of child health disparities are indeed so elemental and profound (and so deeply-rooted in our social fabric) then our daily coalface attempts to improve child health start to look futile.

It is, though, possible to approach the issue in a considerably more constructive fashion: all that is required in adopting a health equity approach is a little change of gaze. Whereas a conventional ‘primary health’ approach may ask “how can we reduce disparities in the distribution of childhood disease and ill-health?”, a health-equity based approach asks instead: “how can we eliminate inequalities in the distribution of *power and resources* that *shape* the pattern of child health outcomes?”

In a sense, the latter makes things easier to address: we see that the conditions that drive health disparities are not natural, fixed or inevitable but rather the consequences of public policy: something we have successfully modified in the past, and can do so again.² History itself provides us with a plethora of examples: indeed, the increase in life expectancy over the 20th century has been close to thirty years in most Western countries, most of which has been attributable not to advancing medical technology or cutting-edge drug development but rather basic social reforms (the eight-hour work day, social welfare schemes, minimum wages, housing subsidies, universal schooling, and progressive business and tax policies, for example).²

New Zealand’s key political bodies have indeed begun to recognise and adopt the health equity manifesto, and its particular pertinence to paediatric populations has not gone unnoticed. The recent NZMA position statement devotes a large portion specifically to child health, calling (for example) for “high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient”.¹

In its recommendations, the statement recognises the need to empower children and young people, and calls for reductions in social gradients where skills and qualifications are concerned. Equitable educational access is emphasised, and there are also calls to increase child health advocacy, adopt more holistic whole-of-government child health approaches, move toward integrated child health service delivery models, and boost monitoring of child health according to key, established indicators.¹

The recent Marmot Symposium (held in July 2011 in Wellington, as a collaboration between the NZMA and the Health Inequalities Research Programme) also cast new medical and political light on health equity issues, with paediatric issues highlighted as a key focus area.⁷ Indeed, the fact sheets created for the symposia list “maintaining and enhancing investment in early childhood” as a key, numerated ‘top-ten’ intervention priority.⁷ Specific recommendations extend to a need for “visible leadership that champions child health and wellbeing”. There is a call for a reduction in child poverty rates, and an assertion that “...there needs to be greater coordination among services for children, and a visible cross-party agreement that determines the strategy for improving the environment in which children live”.⁷

In essence, a health equity approach demands that we think less as doctors and more as national and global citizens, justice crusaders, and engineers of social change. Just as the *origins* of illness and of health extend far beyond individuals, bodily pathologies and cellular processes, so too do the solutions. We will be off to a good start when we, as clinicians, realise that our role in child health extends beyond the operating theatre and the clinic room: we need to be present in debating chambers and select committees, on evening news programmes and international policy boards, at global conferences and within governmental agencies.

Campaigns for *social justice* are the most powerful opportunities of all to increase child health and wellbeing, and struggles over labour conditions, housing schemes, food security and education budgets are as much health initiatives as are more familiar 'primary health' schemes (immunisations, screening programmes and healthy eating campaigns).

To quote Dr David Williams of the Harvard School of Public Health, "housing policy is health policy. Educational policy is health policy. Antiviolence policy is health policy. Neighbourhood improvement policies are health policies. Everything that we can do to improve the quality of life of individuals in our society has an impact on their health."²

Competing interests: None declared.

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