

## **Editorial: The public's health, inequalities & social justice**

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### **The public's health**

*The public's health* celebrates the move away from the traditional division between curative or clinical services and public health or population health programmes. We embrace the model of 21<sup>st</sup> century health systems as needing to integrate prevention, promotion and treatment; climbing out of the silo of 'the health sector' to a more flexible, digitalised, inter-sectoral, community-oriented world. A starting point for action is assessing the public's needs and preferences, giving priority to those with the greatest needs, and promoting community empowerment from the 'get-go'. Investment in primary prevention targeting poor communities has to be a top priority. Yet, prevention interventions will not be very 'medical'; indeed they will involve a whole range of actors across society taking account of social and economic context (or 'the social determinants of health'). We recognise that prevention or promotion programmes cannot be conducted in isolation from quality health care, with combinations of interventions needed within a multi-sectoral paradigm (Baum, 2008). Such a paradigm must address the social determinants of health (the societal conditions into which people are born) and in so doing address health inequalities (WHO, 2012).

### **Health Inequalities**

Debates about *health inequalities* grow in importance. Whilst there is a decline in absolute health needs globally and locally, there are increasing differences between the health of the rich/richer areas and the poor/poorer areas, within countries as well as between countries and regions (Sumner, 2010). Poor populations or communities face educational and employment disadvantages, voicelessness and powerlessness in absolute terms, and this has a significant impact on their health. The global poorest of the poor, who lose out most in this environment of inequality and injustice, are referred to by Sumner (2010) as *the bottom billion* people in our world.

Notions of *health inequalities* are associated with unfairness "when poor health is itself the consequence of an unjust distribution of the underlying social determinants of health" (Woodward & Kawachi, 2000, p. 923). Various sources debate both the interchangeability and the distinctiveness of the related terms *inequality*, *disparity* and *inequity* (Braveman, 2006; Whitehead, 1990; Woodward & Kawachi, 2000). Perhaps the key distinction is made between inequality/disparity and equity. The concept of equity has a moral and ethical dimension rather than a focus on numerical difference. While disparities or inequalities may focus on variations in "status, opportunity or treatment", "inequity incorporates an assessment of fairness" (UN, 2009, p. 4). UNAIDS (2011) identified the "social determinants of health [as] mostly responsible for health inequities, the unfair and avoidable differences in health status seen within and between countries" (p. 27). Braveman (2006) made the distinction between advantaged and disadvantaged groups; "disadvantaged social groups... systematically experience worse health or greater health risks than more advantaged social groups". (p. 167). Furthermore, Birn et al., (2009) defined 'social inequalities in health' or 'health inequalities' as the "systematic and persistent differences in health between and among different social classes, genders, racial and ethnic groups, occupational groups, and so on, as linked to underlying power and structural differences" (p. 341).

Baum (2008) noted that “greater equity in health will come from structural change in the distribution of social and economic good” (p. 410). This is a key point - that without fair distribution of wealth/resources/opportunity in any society there cannot be equity. The implications of this for public health related policy and systems is that structural change must occur if there is to be greater equity. Structural change means more than fair distribution of health resources. Rather it relates to other relevant sectors, such as employment, education, taxation, or all the macro changes required in a society to move people from positions of poverty and social disadvantage to wealth and advantage. Without structural change, re-distribution of resources and opportunity, the status quo of inequality is maintained.

## **Social Justice**

The notion of ‘fairness’ emerges from this discussion of inequality and links with the next idea we discuss; that of *social justice*. Social justice includes notions of fairness and discourses and strategies which counter vulnerability and promote positive change. This includes discourses and strategies with regard to strength, capacity, voice, inclusion, empowerment, and participation, and that are emphasised by values of social justice and rights. Rawls’ influential theory of social justice as fairness is underpinned by principles for regulating inequalities that arise from historical chance and other factors (Rawls, 1999). These ideas of social justice, fairness, and rights have been influential with health policy makers globally and nationally. They are important frameworks or value systems for supporting approaches to health inequalities. Central factors are the relationship between health and justice, how to determine when health inequalities are unjust, and what mechanisms might be applied (Blacksher, 2012).

Social justice should encompass policy changes as well as public action to eliminate health inequalities. The World Health Organization’s Commission claims that “social injustice is killing people on a grand scale” (Blacksher, 2012, p. 320). Often research discussing social justice addresses distributive fairness or distributive justice (Mackie, 2010). Issues that should be considered important in both public health and social justice often continue to be marginalised in the curricula that is taught in many health professional training institutes, including public health schools (Donohoe, 2013).

“The most fundamental idea in this conception of justice is the idea of society as a fair system of social cooperation over time from one generation to the next” (Rawls & Kelly, 2001, p. 5). The notion of social cooperation and distributive justice requires the practical application of mechanisms for wealth and status distribution.

*“Justice stresses the fair disbursement of common advantages and the sharing of common burdens. It captures the twin moral impulses that animate public health: to advance human well-being by improving health and to do so by focusing on the needs of the most disadvantaged. An integral part of bringing good health to all is the task of identifying and ameliorating patterns of systematic disadvantage that undermine the well-being of people whose prospects for good health are so limited that their life choices are not even remotely like those of others” (Mackie, 2010, p. 621).*

The persistent use of the term social justice in the WHO report on social determinants of health has encouraged public health workers to be more assertive in demanding social justice as a principal value in public health (Gatherer, Fraser, Hayton, & Moller, 2010). However, there continue to be barriers to a social justice agenda. An effective response requires: a) a need for a social consensus around the issue of redistribution of wealth to achieve equity in many societies; and b) a move away from an overly medicalised idea of health (Baum, 2008).

## Locating these themes in New Zealand

In 2002 the New Zealand Ministry of Health [NZMoH] defined health inequality as “differences in health that are unnecessary, avoidable and unjust” (2002, p. 27). The NZMoH (2002) noted ethnicity as the key influence shaping inequalities in health between different population groups in New Zealand. NZMoH called for a population health approach which addressed ethnic, gender, socioeconomic and geographic inequalities factors, thus incorporating an agenda of health inequity and social justice. Yet if addressing inequity is indeed a core value of public health, why does the New Zealand government and society tolerate so much inequity and social injustice? (Fraser, Gatherer, & Moller, 2009). Partial explanations of this stasis is the lack of real political will and social consensus to make the required structural changes. More broadly, there is a reluctance in the society at large to address the problem of inequalities, despite a plethora of debates (Rashbrooke, 2013; ‘Inside New Zealand: Mind the Gap’, 2013). NZMoH aspirations seem at odds with an environment, locally and globally, which is increasingly weak at regulating payment of tax by wealthier populations and institutions and engages in inequitable tax practices that disproportionately benefit the wealthy and disadvantage the poor. Today, New Zealand still has significant health inequalities despite the rhetoric of policy makers, especially amongst different ethnic and racial groups (Blakely & Simmers, 2011). Therefore the need for structural change is stronger than ever.

## Contributing papers in this issue

The paper by Ellen Nicholson, building on her expertise in participatory research explored through her doctoral study, goes to the heart of this issue. She examines the theme of child poverty in New Zealand and the potential of participation to contribute to solutions to this serious problem. This paper reveals that potential, principally through exploration of child poverty as a social justice issue. Participation is viewed from a range of perspectives, focused on improving the health and wellbeing of children living in poverty.

Peter Simunovich’s paper examines a different section of the New Zealand community, that of the elderly population, and disadvantage they may face in relation to health professionals. This paper arises from his Masters of Public Health study. In his view, the manner in which older persons are treated when seeking health care may well reflect either an environment of care and dignity or placation and dismissal. His analysis poses several questions. Is ageism a threat in the New Zealand health service? What policies exist nationally and internationally which protect older citizens from unfair and inequitable health access?

In Ayan Said’s research an important public health problem resulting from gender inequalities is explored. The paper on female genital mutilation (FGM) arises from Ayan Said’s research for her Master of Public Health. She also draws upon her experiences as a member of the Somali community and an outspoken advocate and educator for the prevention of FGM in practicing communities. Her paper discusses the way this cultural practice causes harm and has many side effects both physical and psychological. In New Zealand there are no public health policies that directly address the issues of FGM but programmes related to FGM have been referenced in the New Zealand Health Strategy.

In his research, Kamrul Hasan analyses another aspect of health inequalities arising in the context of primary health care in rural Bangladesh. As a Development Studies Masters’ student at the University of Auckland, Kamrul studied health professional power in the context of one *upazila* (district primary health care centre) in rural Bangladesh. He elicits the stories of a small group of users who describe incidents of professionals’ corrupt behaviour and abuse of power. Based on participants’ experiences, the paper discusses means to reduce such conduct, including the potential to harness resistance and protest as community empowerment.

HIV/AIDS as a sexually transmitted disease is an important global health issue. At-risk groups such as men who have sex with men (MSM) face considerable stigma and negative attitudes and this creates inequalities in their ability to access services for HIV/AIDS. Sansanee Chanthasukh, an AUT PhD candidate from Thailand, presents a small-scale review of literature on the issue of stigma and negative attitudes towards MSM. A key theme discussed in her review is that stigma encourages MSM to conceal their homosexuality and HIV-positive status.

Carol Maibvisira's paper is somewhat contrasting with those above in that she presents her story from her PhD fieldwork. She presents her experiences of carrying out fieldwork in her hometown of Bulawayo, Zimbabwe where she partnered with young people to investigate, through participatory research, their perspectives on the effectiveness of HIV prevention sex education in Bulawayo schools. African youth face considerable challenges, both in terms of socio-economic disadvantage, and also, in relation to how HIV prevention has been modelled reflecting wider societal, youth and HIV specific inequalities.

HIV prevention is a major focus of research in the Department of Public Health at AUT and this is reflected in some of the papers here and in the brief report about the 1-day HIV Symposium coordinated by Dinar Lubis, doctoral student from Bali. The Symposium was well attended by staff and students from Massey, AUT, University of Auckland and New Zealand AIDS Foundation with a range of presentations about HIV research in different communities locally and internationally.

## **Conclusion**

This research is central to this inaugural issue and representative of the Department of Public Health's priorities contributing to global and local debates on inequalities and social justice. As we undertake research, by and with disadvantaged people, we constructively engage in the wider critique. To what extent are the various initiatives and policies just 'talk' rather than effective and enforceable strategies? Is there sufficient political will and social consensus to carry through on policies that genuinely address inequalities? If a consensus exists, what are the best mechanisms to move forward? There are examples of countries or regions that have been successful in achieving more equitable societies, and we can learn from them; but they face considerable challenge in sustaining equity gains.

In a society made up of "healthy people in healthy communities" (U.S. Department of Health and Human Services, 2010, p. 2) health inequalities would cease to exist. Key priority health improvement areas have been identified as part of the World Health Organization's (2013) global health agenda. These include the need to 1) promote socio-economic development, as poverty is often related to poor health; 2) foster international health security by reducing the occurrence and spread of epidemic diseases; 3) strengthen country health systems through making these responsive, particularly to the needs of low socio-economic populations, and; 4) harness research, information and evidence to inform the generation of effective policies. As an academic community we continue to strive for changes to policy and practice which create real reduction in inequalities and promote a social justice agenda.

As Gostin, Boufford, and Martinez (2004) have stated, we already know that the challenge of improving the socio-economic conditions for health requires redistribution of wealth and opportunity. There are those who argue for a need to change the inequalities and social determinants language, moving away from the political polarisation of left and right thinking to achieve the community buy-in required to address this issue (Robert Wood Johnson Foundation, 2010). Others suggest we need new and ambitious global financial mechanisms (for example, Picketty's (2014) proposal for a global wealth tax system). These strategies advocate for more radical shifts away from 'business as usual'. The challenge of wealth distribution is not only an issue for New Zealand but a global issue of considerable proportions requiring a national and global response. We are very excited to be part of 'real strategies' for addressing inequalities and promoting social justice in the 21<sup>st</sup> century.

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