Disability and Equity in Medicine and Public Health

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Abstract

The notion of 'equity' in a New Zealand context is often tied to Māori, in particular. It is sometimes acknowledged that there are equity groups in New Zealand other than Māori, however, and we need to understand how this can be so without taking anything away from Māori - in part because there is so very much more, yet, that needs to be done with respect to attaining equity for Māori. I will consider three notions of equity that we do well to acknowledge: Firstly, fairness of distribution. Secondly, equity as an overall amount (e.g, gross domestic product, or an amount of, for example, Treaty Settlement). Thirdly, equity as a fairness of distribution that focuses on maintaining what it is that one has and passing it via inheritance or succession to future generations (e.g, equity trusts). I will argue that the source of equity in health contexts needs to be understood as arising from the human right to health for all peoples that has been articulated by the United Nations. In considering whether or not a policy or legislation or decision is equitable we need to get clearer on our articulation of who the primary beneficiaries are and whether we are empowering the appropriate group - or whether we are entrenching their inequality in the name of equity. I will consider that the best way we have of ensuring the human right to health for all peoples is for all peoples to be represented so that their interests and concerns can more properly be taken into account.

Contents

Introduction

This thesis is a philosophical investigation into equity, with particular reference to disability in the New Zealand context.

Chapter one briefly outlines theories of ill health and disability. The narrative is one of a progression in our understanding as we come to appreciate more of the factors that go into producing and maintaining ill health and disability. While the philosophical story tends to stop with the medical model there has been a more recent movement to consider some of the social forces and economic consequences of disability. I consider some of the tensions arising with respect to sources of power in the creation and maintenence of disability.

Chapter two starts out with an account of inequality between countries, and within New Zealand, more in particular. I introduce some of the evidence that there are major inequalities in New Zealand, with respect to income and wealth (access to resources needed to attain health), healthy housing, and health and health outcomes. I consider evidence that up to this point inequality has been increasing and also evidence that New Zealand is falling behind in the world with respect to the socioeconomic development of it's people. I then consider how given this trajectory it seems reasonable to forecast inequality will continue to rise, going into the future. I then consider the link between inequality and inequity as it has been pointed out that not all inequalities are unjust and there has been a move to try and divorce the issue of health equity (or inequity for certain groups of people) from the issue of poverty, particularly.

This has served to divert our attention from the major equity groups - or the groups who profit the most from our continued focus on inequity and inequity groups. I consider how some inequalities have been formally recognised as inequities and groups of people thus identified as targets for certain contexts e.g., Māori, Pacific Islander, women, refugees, people with disability.

Chapter three takes us from the United Nations to the District Health Boards of New Zealand. I introduce the charter of the United Nations and it's role in promoting peace and security for all peoples. I consider the social and economic development council and it's role. I then turn to the Millenium Development Goals and then the Sustainable Development Goals which include such ideals as the promotion of equality between peoples, equity for people, and the attainment of health and education for all peoples. I introduce the Declaration on human rights and the idea of equality between people in the respects that matter for consideration of them and their interests. I then introduce the World Health Organisations views on equity, health (health targets and health outcomes), and disability. I then consider the New Zealand Ministry of Health whose job it is to try and attain the vision set by these agencies, and, when it seems to run counter to the interests of New Zealand peoples to report this back to these agencies and contribute towards the development of the global vision for peace and security for the peoples of this world. I consider the District Health Boards and their role in implementing the measurable health targets and health outcomes for people in an equitable way.

Chapter four introduces the idea of kinds, or groups of people. I introduce the notion of equity groups, and consider five case studies of equity groups: Sex / gender, racial ancestry / ethnicity, geography, poverty, and disability. I re-consider the themes of chapter two where we have descriptive statistics on differences between groups, prescriptive statistics or future projections on differences between groups, and we have people investing accordingly - which helps to stabilise the trajectory for that group. I then consider how it is more

in keeping with the United Nations directive to focus on empowering groups rather than (continuing to) profit from their disempowerment as we saw to be the case in chapter two.

Chapter five considers co-operation when expedient and co-operation for mutual benefit. I consider mutual benefit is the non-contradictory, rational position that is required for sustainability. I introduce Rawl's original position and the notion of human rights that grounds principles of non-discrimination. I then consider how data collection, discrimination, and equity seem jumbled and recommend we set out two distict steps. Firstly, refraining from discriminating and then secondly employing an algorithm that doesn't reintroduce discriminating. Equity criterion were supposed to be about better futures for more of us, not something expedient for people to appeal to to entrench better futures for an increasingly small minority.

Chapter 1

Models of disability and ill health

There are a glut of notions used in and around medicine when it comes to articulating the subject matter. An incomplete list is an indicator: 'malady', 'illness', 'ill-health, 'abnormality', 'deficiency', 'defect', 'dysfunction', 'disorder', 'sickness', 'disease', 'injury', 'medical or health condition', 'pathology', 'medical or health issue', 'failure to thrive and / or to flourish', status as 'victim of an accident' and 'disability'. One might think that there are important differences in the phenomenon that is (or that should be) picked out by one or more of the terms above. For example, one might think that diseases are biological whereas disorders are behavioural, and disabilities are socio-economic. Or, one might think that there really aren't very important differences in the phenomenon that is (or that should be) picked out by one or more of the above terms because they all (roughly) point towards the same thing: The lack of health or the failure to attain good health.

I don't want to get caught up in a debate around how we should use our terms. As such, I am going to consider something along the lines of one

theory to rule them, all. The story I want to tell here is one that focuses on the aspects of elements that are typically underplayed in standard accounts and in the standard literature. This story will be one of progression, where we are coming to understand more of the variety of factors that play into the phenomenon that afford us a better, and fuller understanding of the causation, and trajectory of disability and disease for peoples. This chapter is paving the way for a discussion of inequality and equity in the next chapter. While this sounds like a mismatched pair these are the standard terms of the debate. I will consider issues around their valence in the discussion that unfolds. We will then be in the position to consider the views of the United Nations and World Health Organisation in chapter 3.

1.1 Pre-medical model

While we may be used to thinking of life before Medicine and Medical Institutions as being nasty, brutish, and short, there is evidence to the contrary. I will briefly consider pre-medical models of disease / disability before turning to the Medical model.

1.1.1 Biological anthropology

Bones preserve relatively well and well healed but deforming fractures and developmental abnormalities provide evidence that early hominins cared for at least some of their people who would have had a hard time hunting and / or gathering in a community where that was the primary way of life. While there is much we don't know about division of labour in particular cases (e.g., whether these people could have or did earn their keep by keeping fire or cooking or making tools etc) we know that severely injured people lived for a number of years post-injury which shows they were not simply left to die once

they had outlived their usefulness as hunters or gatherers for the group. There has been some speculation that fire-tending might have been the first divison of labour in traditional hunter-gatherer societies and it might be plausible to think that differences in mobility, for example, could well have contributed to variability in behaviour resulting in the discovery of different sorts of things that turn out to be useful for the group.

There is also evidence of very well healed severe injuries that were either congenital or suffered very early on which shows that children, also, were not simply left to die if they appeared different, either (e.g., Oxenham, M., et al., 2001). It is possible that those who were different were marked out early as religious leaders / healers / shaman for the group and / or that differences in ability / mobility may have been a driver for division of labour for those who were unable to contribute towards hunting / gathering. There is, for example, some evidence that epilepsy and religiousity are linked due to some overlap of temporal lobe functioning. This seems to have some degree of intuitive plausibility if we consider seizures as an indicator of epilepsy and the overlap there seems to be with elements of religious experience such as around the notion of possession by demons or gods. The sense of conviction experienced by those with delusions has also been linked to religiosity where the later involves a conviction or certainty about the existence of god or gods.

1.1.2 Evolutionary game theory and strategic role enactment

A literature has developed around the issue of how it is that co-operation or altruism has evolved (e.g., Frank, 1988). The problem is that the most short term profitable strategy on interacting with others seems intuitively to be one in which an individual takes what they can get when they can get it because

they can get it and never mind what that leaves for others. The issue is that co-operative (sharing) or altruistic behaviours always seem to fare worse for the individual than psychopathic, cheating, or defecting behaviours would. As such it is hard to see how co-operative or altrustic behaviours could have been maintained in populations instead of being driven into extinction by the presence of psychopathic, cheating, or defecting behavioural strategies.

People have tried to solve the problem of the evolution of co-operation by getting clearer on the mechanisms that go into allowing, or promoting it. For example, while it might seem that psychopathic /cheating / defecting strategies pay off the best in one-off interactions, the possibility of that individual being punished by others, or of being excluded from future interactions as the result of their behaviour, might be sufficient to enable co-operation to persist in populations where there are a number of cheater and defectors.

While turning to longer-term pay-offs might seem appealling it is important to remember that evolution by natural selection is not goal-oriented. We can't explain the evolution of the eye from some initial state to some useful end state by way of middle steps that are worse than the initial state in the short term because of the greater utility to the create later down the track once it reaches the goal of the fully formed eye. Rather, each of the middle steps needs to fare not overtly worse than the previous state *in the short term* to explain how it was that it was able to exist in competition with the previous state for long enough for the next state to appear on the scene.

This may be relevant for illness / disease / disability insofar as we think that this is appropriately modelled as a case where an individual does not contribute their share to society A common view of disability is one in which people are unable to contribute and apparantly this is what explains the significantly higher levels of unemployment for people with disability. If this isn't the case then it might be that discrimination against people with disability is primarily responsible for their higher levels of unemployment. Whether it be because an

individual cannot (in the case of illness or disability) or because an individual simply does not or chooses not to (as - perhaps - in the case of at least some theories of sociopathy and / or criminality) the effect (one might argue) on a co-operative society is the same. That is to say, it appears to be undermining. We should be concerned about a society in which the prevalence of disorder / disease / disability becomes too high because we are dealing with a society in which co-operation is dwindling.

1.1.3 Spirituality and religion

Abrahamic dietary restrictions may have helped populations stay well (e.g., prescriptions involving burning and washing rituals) and prevent illness (e.g., prohibitions of excess, and of eating certain items which may have passed disease, such as from eating the flesh of animals that are likely to infect humans with parasites). Failing to keep these religious doctrines or rituals might well have increased an individual's chances of becoming ill. There may well be something to the notion that illness was more likely to result from sin or moral failing when we understand factors surrounding those practices for those communities.

The story of Job, on the other hand, is a story not of sickness as punishment for sin, but as something to be endured as a test of faith by a basically upstanding person, however. As such, we have old testament scripture attesting to the idea that illness, disease, and other misfortunes are not always punishment for individual excess or vice. Churches have traditionally been in the position to distribute resources to those in need as people brought their resources to the church (to be stored in physical structures). The notion of the church taking or redistributing part of that (as tithing) might be seen to be a sort of social insurance administrated by Church organisational structures. Many religions have the idea of church tax or charitable donation to help those in

less fortunate positions than themselves currently (e.g, tithing, zakat, daan, tzedakah). Priests and elders etc would have made decisions about who was a morally upstanding worthy recipient of aid compared to who was being punished for their sins.

1.2 Medical model

The Medical, or component process model is typically considered to be an advance on the spiritual model for the virtue of being grounded in objective facts to be discovered by science rather than by the opinions or judgements on the moral standing of the person afflicted as had (arguably) been the case prior to Medicine. Progress was made in anasthetics (pain relief and as a result, better surgeries), antibiotics, and immunisations (particularly the elimination of smallpox). The idea is that sickness, disease, disability is caused by breakdowns or disruptions to - physiological, biochemical, genetic, or physical (i.e., mechanical) - systems or components of organ systems. The story, now, is a causal pathway story that removes all blame and responsibility from those who are afflicted by locating the problem in factors outside their control. The hope is that as medicine continues to advance many or most or all medical conditions will come to be eliminated the way that smallpox or a tumor may be removed or eliminated by way of medical treatment.

1.3 Social model

Let us now turn to three broadly different strands or threads to the social model. The first is roughly an extension of the medical model to include some of the social and environmental causes of ill health. The second is the consumer led disability rights strand that focuses on the harm arising from the social and

environmental causes of ill health and sources the major harms there rather than as the direct result of the medical, or component process affliction. The third is the more radical social constructionist view that results in theorists being eliminativists about a person being disordered (saying they are not) or a condition being a disorder (e.g., we have come to be eliminativists about homosexuality as we have eliminated the diagnosis from the *Diagnostic and Statistical Manual of Mental Disorders* and the International Classification of Diseases Index. The point is that people are no longer trying to eliminate homosexuality by way of medical intervention. Rather, we have come to accept that some people engage in sexual behavior with people of the same gender as themselves. We have chosen to eliminate homosexuality from medicine rather than eliminating homosexuals from humanity, in other words.

I will then consider tensions arising from these three strands of social construction which has led to controversy and dissent amongst people with disability.

1.3.1 Public health

Public health arose out of medicine. The standard story is that John Snow is the founder of public health or epidemiology because instead of his focusing on *Vibrio cholerae* infection in his patients as the cause of their cholera, he focused on faecal contamination of public water supply as being the cause of his patients illness. Chimney sweep's carcinoma is another example of how, this time, an occupation is identified as being a cause of illness, instead of the focus being on the accumulation of genetic mutation responsible for particular patient's cancers. Today, clinicians who focus on social determinants of ill health for their patients (e.g., occupational hazards, unhealthy housing) are clinicians with a public health focus. Most practicing clinicians say they are not trained to have a public health focus. Clinician's are typically expected to focus on the components of their patient's (providing generic medications or minor

procedures) or referring their patients on for such treatments and they are not to concern themselves with, for example, lobbying the government on their patient's behalf for better living and working conditions. This is particularly the case when the government is the medical professionals primary employer.

Typically people who regard themselves to be working in Public Health are not clinicians (i.e., they were not trained in Medicine and / or they are not currently lisenced to practice as Medical Doctors). Sometimes public health is characterised as being health promotion (e.g., working to develop the traffic light system for food choices, or to develop smokefree campaigns). These are thought to be empowering for consumers of the health system insofar as they are thought to provide education so patients can take responsibility / blame for their health outcomes. Sometimes public health it is defined as being the same as epidemiology - or population health. It is a short step from the notion of population health to issues of resource allocation that will be considered later under the rubric of the economic model.

1.3.2 Disability rights

The rallying cry of the international people's movement has been: Nothing about us without us! as people with disability have tired of having the course of their lives dictated to by others without their being properly consulted on the issue (Charlton, 1998). The disability rights movement is usually considered to have started with the idea of deaf culture. Here we have the idea of a group of people with a language - sign language - advocating for their right to use their language to communicate and not be segregated or excluded because they are deaf (Durham, Brolan, and Mukandi, 2014). Autism and autism spectrum advocacy groups and the autism rights movement have also campaigned for people with Autism to be viewed as peoples who are different - rather than as individuals who are broken, defective, or wrong for not behaving in a way

that is more in keeping with what is regarded by the majority to be normal or acceptable behaviour. The Neurodiversity movement has gained momentum as a number of people have campaigned for them being different, but not necessarily worse, because of their difference (Mcgee, 2012). Parents have also had a considerable role to play in advocating for their kids to be accepted in society, e.g., in cases of Down's Syndrome.

The main focus of the disability rights movement has been something along the lines of how disability arises from contingent features of our social environment rather than from anything intrinsic to the medical condition or issue that people have. For example, people don't deny that deaf people can't hear, but they do deny that this inevitably must result in lack of communication since sign language is a language in all important respects. If people who can't hear have trouble communicating in this day and age given sign language and written language and so on, then this is a problem with our society more than a problem within the hearing impaired individual.

1.3.3 Social constructionism

We saw the public health view considered social determinants in a way that expanded upon the medical model. We also saw that the disability rights view considers that the costs and harms of disability are less to do with medical dysfunction but are more social in focus. The disability rights movement may also be viewed as less supplementary to Medicine as advocating more that disabled people themselves are authorities with respect to what it is that is good for them, or what it is that they need. A social constructionist model is even further from the medical model, however. A social constructionist model - at least, on the way that I am telling the story here - is debunking.

For example, let us consider homosexuality as a condition that used to be

regarded as a medical - psychiatric - disorder. People who had been identified as homosexuals (at least some of the time) could be involuntarily detained in psychiatric institutions and be treated, against their will, with medications and electric shocks etc to try and cure them of their homosexuality. This was done to a number of people. Social constructionists about homosexuality say that we were wrong about homosexuality being a medical - or psychiatric - disorder. We used to think it was a disorder - but we were wrong. It never was and was incorrectly regarded to have been so.

Another debunking story along similar lines is the social construction of childbirth as a medical phenomenon. The idea is that we were wrong to consider pregnancy a pathology, to think that that the appropriate place to give birth is a hospital, to think that medical doctors are the relevant source of authority for natural childbirth (as opposed to surgical removal of the foetus). To this we could add another debunking story of the social construction of the female sex / gender as being constitutionally a malformation of the male variant with less work capacity etc due to it's tendency to be afflicted with this disease of pregnancy and childbirth.

On the way that I have told the story, here, the social constructionist does not deny that at least some people do engage in homosexual behaviour at least some of the time, that some women do become pregnant and give birth to children, that there are women. The social constructionist simply denies that these are medical conditions and denies that there is something objectively scientifically wrong or broken or malfunctioning about these individuals.

I interpret this latter line as a kind of eliminativism with respect to homosexuality. I will explain this by analogy. We used to think that there was this substance - phlogiston - that was responsible for transfer of heat between objects. We learned that while heat will form an equilibrium between objects

there is no transfer of heat fluid and we have come to eliminate this notion of phlogiston or heat fluid from our scientific theories. Similarly, we used to think that there was a mental disorder - homosexuality - that was responsible for people sometimes engaging in sexual behaviour with people of the same gender as them. We learned (or have come to believe) that while some people do engage in sexual behaviour with people of the same gender as them sometimes this is not due to mental disorder. We have come to eliminate the notion of homosexuality as a mental disorder from our psychiatric (and clinical psychological) theories.

1.3.4 Tensions for social models

Social models are controversial. Some people with disability or carers for people with disability see them as empowering. Other people with disability or carers for people with disability see them as disempowering.

Social models can be empowering because a medical diagnosis can help people feel like their distress or problems are legitimated, somehow. Medicine typically commands respect and Medical professionals may be seen as relatively powerful support people or allies to have onside to help people get the resources they need. Medical diagnosis may enable people to get medication or treatment they believe they need. Children might be provided with additional assistance at school. Parents might be given more resources to purchase housing modifications, etc.

On the other hand social models can be disempowering because a medical diagnosis can prevent people from living the lives they wanted for themselves. Medical diagnosis can result in people being involuntarily incarcerated and subjected to invasive procedures (e.g., given injections of medications or elec-

tric shocks, or even surgeries to their brain, for example) against their will. Medical diagnosis can result in people not being listened to with respect to what people want to do with the resources they have (e.g., as when an elderly person is diagnosed with dementia and their assets are ordered to be liquidated to fund the high care institution / hospital they have been court ordered to reside in for the rest of their days.

If one cuts off ones thumb one cannot hold a sword and thus cannot be drafted to war when swords are the relevant technology. Medical Doctors have played a role in diagnosing people with conditions which exempt them from military draft e.g, 'flat feet'. Soldiers were diagnosed as suffering from shell shock and / or post-traumatic stress syndrome and these diagnoses were thought to be helpful to war veterans because it got them out of a situation they desperately needed / wanted out of and it gave them treatment options and more understanding responses from the public later in life.

Today, some people are required to get a note from their doctor if they take time off work for sickness. Their employer will not take their word for it, but if they tell their doctor they are sick and their doctor writes them a note saying 'so and so saw me on such a such a date and told me they felt sick' the employer will accept this as confirmation of illness. Or perhaps a person knows their home is unhealthy because it is too cold and humid but even though they mention this to their property manager / landlord the response is to move out since there is no shortage of replacement tenants so if you don't want to live there - move out. Governments may be less likely to respond to citizens complaints than to medical doctors complaints when medical doctors can make a case that (for example) children's respiratory problems are likely exacerbated by living in unhealthy homes. Medical support for what is perceived to primarily be a medical problem might be more likely to result in government

officials choosing to improve New Zealand building legislation / tenancy laws so there is incentive for landlords to improve them such that they are more in line with those found in developed nations.

Medical paternalism might be a good thing for people who are diagnosed with a medical condition. Medical doctors may be able to help people make a case and to provide the weight of Medicine and Medical institution and expertise to the situation. On the other hand medical paternalism might not be a good thing for people who are diagnosed with a medical condition when it results in taking power away from the individual. For example, individuals who are diagnosed with certain conditions like schizophrenia, borderline personality disorder, substance abuse, are often thought to be given a life sentence which effectively prohibits people from recovering or for ever being accepted as having recovered by society. A psychiatric (medical) diagnosis of one of these conditions might be as effective (or even more effective) in preventing a person going on to professional career than if they had been not only charged but actually convicted with criminal activity involving serious misuse of power (e.g., sexual offending or violence against children).

People with medical diagnosis and people seeking medical diagnosis for themselves or people they love may be divided about medicalisation. On the one hand, medicalisation and medical support might be seen by them to be the best or only way they have of potentially getting the things that they need. On the other hand, medicalisation and medical 'support' might be seen by them to be what is preventing them from potentially getting the things that they need. Some people hope for medical cure and fear allied health professionals taking control or other non-health government or non-government agencies.

1.4 Economic model

We do not usually hear of the 'economic model of disability' but there is a model of disability that goes into the notion of 'Disability Adjusted Life-Years' or DALYs criterion that is sometimes appealed to by management or administration when it comes to decisions around resource allocation, particularly in the public sector. The idea is roughly that the notion of 'disability' in the DALYs criterion is something along the lines of the notion of a deficiency when it comes to the attainment of health.

The World Bank has commissioned Global Burden of Disease studies since 1990 where there is an attempt to quantify the health effects of different diseases and injuries with respect to morbidity and mortality by age, sex, and region. The notion of a disability-adjusted life year (DALY) was invented as a new metric to quantify the burden of disease, injury, or risk factor. Once we have a metric for the burden of disease we can then look at the efficacy of various treatments or interventions and their calculate (for example) such things as the cost-effectiveness of various interventions. DALYs are calculated by taking the sum of years of life lost due to premature mortality (YLL) + YLD, where YLD is the years (of healthy life lost) due to disability. The later is meant to be a measure of the burden of living with a disease or disability. We can also consider the notion of disability weight (DW). For example, the disability weight of deafness in 2010 was 0.167-0.281 whereas the disability weight of blindness was 0.195 while Alzheimer's and other dementias was 0.666 (World Health Organisation, Department of Health Statistics and Information Systems, 2013).

The idea, here, is that most people don't simply want medicine and medical treatments that promise to extend their lives, indefinitely, but most people want medicine and medical treatments that are likely to contribute towards their having an extended quality of life. So, the extension of life (the 'buying

of time') that medicine and medical treatments are often thought to provide, needs to be moderated against the quality of life of the recipient. For example, a person who is brain dead (who has irrevocably lost all motor function and higher cognitive processing) can be kept alive fairly much indefinitely on a ventilator and other life sustaining machines and procedures. Many people have an aversion to such a life, however. They would say that if this happened to them they would not wish to be kept alive indefinatily on a ventilator. They would want the goods and services involved in keeping someone alive on a ventilator to go to someone who could use them in order to attain a higher quality of life - i.e., someone who had a chance of recovering from their coma with cognitive function. If there was a shortage of ventilators many people would elect not to be placed on a ventilator at all if that would make it more likely the ventilator could be used to save someone who can then go on to attain a higher quality of life.

One issue is what we say in the cases where people don't seem to want to, so to speak, play ball for the common good. The above case was a case where the person said what it is that we perhaps wish people would say. There may well be people who think that they would like to be kept alive on a ventilator indefinitely in case medicine develops such that there is a cure or a treatment for them. In this case I think many of us have the same intuitions that we had in the last paragraph about what should happen. While I haven't done a survey around 60 first year students seemed to agree that there was something wrong with a person insisting that someone stay on a ventillator when they wouldn't recover, and most especially there was something wrong with doing this when the person on the ventillator had previously expressed the desire that this not happen to them to their next of kin. We may feel disappointed in this person for not seeing things that way, however. We might think that this is ethically controversial whereas the above was not ethically controversial, it was obvious what should be done.

It seems rather a stretch again to go from the cases set out in the above two paragraphs (that motivate the issue that quality of life is a consideration not just quantity of life) to the idea that, for example, people who are deaf will not be placed on transplant lists (or ever make high enough ranking to obtain transplant) because their life after transplant will always be DALYs ranked lower than an individual who is comparable in every other way - except that they can hear. The DALYs notion has come to be applied to a measure of the worth or value of a life. A person with disability will always be DALYs ranked lower than a person without disability. A person with disability will always be discriminated against in virtue of their disability in a system where DALYs criteria is used to decide issues of health resource allocation.

An alternative to DALYs criteria is a consideration of what issues are clinically relevant. Hearing impairment is not clinically relevant to the issue of liver or heart transplant. The surgical team isn't likely to have a worse result in virtue of the recipient being deaf. On the other hand, it is clinically relevant that a person has high blood glucose or high blood pressure because these are likely to impact on the surgery and / or recovery from surgery. This is not an issue of discriminating against people on the basis of their disability (diabetes or a vasculature condition) it is about consideration of what is and is not likely to produce the desired result of a good recovery from the operation and reintegration back to previous life. Haplotype matching is also under-utilised - it would be possible to be fussier about prioritising the best haplotype match. Again, we don't need to discriminate against 'alcoholism' when it comes to liver transplants, we can focus on drinking behaviours. We need not discriminate against people on the basis of disability. We will go on to consider why it is that people seem determined to discriminate against people with disability. By way of preview doing so is easy, cheap, and better for those who are

discriminating's own interests - narrowly conceived.

I really do not with to consider DALYs in very much more detail. More particularly, I do not wish to become enmeshed in the standard ethical dialogue with the standard terms of the debate as outlined by (for example) the Stanford Encyclopaedia entry on 'Disability and Health Care Rationing' (2016), or what many standard bioethical textbooks have had to say on the issue of healthcare rationing. It seems to me there is an elaborate set up that has gone in to fixing the terms of the debate. For example, there are a number of assumptions that we are required to make in order to find ourselves in this mess of a problem of resource allocation. More particularly, we are required to believe that the resources needed to attain health are finite and there will never be enough to meet demand for them.

I have come to wonder whether this situation is like the one in which a government decides, for example, that it is acceptable to aim to keep unemployment at around 5 per cent because that has certain effects on the balance of power when it comes to employer / employee relations. Particularly, when it comes to working conditions, remuneration, and generally how well or how poorly employees may be treated by their employers. Of course the converse of that is whether employers can actually employ anyone at all to do the work that they require of them. The issue then arises of what kinds of work we can get people to do if they believe that work is required of them.

In the next chapter we will turn to the issue of resources needed to attain health. For now, I want to end this chapter by introducing an idea that has been touted that there is an inevitable conflict between equitable or fair distribution of resources and the amount of resources that there are overall. For example, the idea that a fairer distribution of income in New Zealand would

result in an inevitable decline or decrease in overall productivity or gross domestic product. The idea seems to be that the 'money makers' only do the work they do because they are able to keep the fruits of their labours. If this really were the case, though, then it would seem that more people could be induced to make more money by allowing them to keep more of the fruits of their labours. Presently, many people labour out of fear of being excluded than out of desire to contribute more towards a society that is moving in positive directions for more (and / or a greater proportion) of us. Many people have lived in fear of being labelled as disabled because that has meant they have been de-prioritised for health care.

For now, let us just consider that the 2013 census in New Zealand resulted in rates of disability at 24 per cent. That is nearly one quarter of our population. We are told that while it might be a nice ideal that these people get the treatment they need, there never will be enough to meet demand. Let us now turn to what I see to be the major question: If there isn't enough - then where does the money go, then?

Chapter 2

Inequality and inequity

2.1 Present inequality

There is much inequality in the world. Both between different countries, and within countries. In *The world development report 2006: Equity and development* The World Bank describes both issues, vividly, by introducing us to three individuals born on the same day, and describing the differences in their life chances (2005, pg., 1-2). Let us meet these three individuals:

> Nthabiseng: Black, born to poor rural family, 700 kms from Cape Town to a mother with no formal schooling.
>
> Pieter: White, born to wealthy rural family in Cape Town to a mother who completed college degree from prestigious university.
>
> Sven: Born to average Swedish household.

Of course, these aren't particular people. Rather, they, they are descriptions of people who vary on a number of parameters (born in South Africa vs Sweden, born in Rural vs Urban South Africa, Male vs Female, Black vs White, level of educational attainment of mother). Classification of people on the basis of

such parameters allows us to group them with 'like' individuals such that we can predict their life chances. For example, to say that Nthabiseng has a 7.2 per cent chance of dying in her first year of life, is to say that, on average, of all the individuals like Nthabiseng (in certain respects), 7.2 out of 100 individuals in that group will likely not make it past their first birthday.

2.1.1 Between countries

The World Bank (2005, pg., 1-2) describes the life chances that may be assigned to the above individuals on the basis of their circumstances:

> [Sven's] chances of dying in the first year of life are very small (0.3 per cent) [compared to 7.2 for Nthabiseng and 3 for Pieter] and he can expect to live to the age of 80, 12 years longer than Pieter, and 30 years more than Nthabiseng. He is likely to complete 11.4 years of schooling - 5 years more than the average South African... in the eighth grade, Sven can expect to obtain a score of 500 on an internationally comparable math test, while the average South African student will get a score of only 264 - more than two standard deviations below the Organisation for Economic Cooperation and Development (OECD) median. Nthabiseng most likely will never reach that grade and so will not take the test.

The Commission on Social Determinants of Health Report (2008, preamble) paints a similar picture of differences in life chances with respect to geographical country of birth:

> Our children have dramatically different life chances depending on where they are born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years.

There is much inequality in the world.

2.1.2 Within a country

We saw, above, that the life chances for Nthabiseng was different and very much worse than the life chances for Pieter, even though they were born in the same country. With respect to inequality within New Zealand my main source is the 2013 edited collection *Inequality: A New Zealand crisis*. Rashbrooke (ed.), and other authors, summarise statistics that they have compiled from a variety of sources, and primarily from international or New Zealand Government reports. Instead of attempting to reinvent the wheel, my aim, here, is to relate the problem of inequality that has been so articulately described by others, in order to pave the way for the philosophical inquiry that is to follow. With this end in mind, Rashbrooke relates how:

> Rising income inequality in many developed nations has been a source of growing international concern... the *Global Risks 2013* analysis prepared for the World Economic Forum summit in Davos, Switzerland, identified 'severe income disparity' as the greatest threat facing the world economy; this assessment was based on a survey of over 1,000 experts from industry, government, academia and civil society (Rashbrooke, 2013, pg., xi)

Rashbrooke describes how New Zealand was historically one of the developed world's more equal societies but there was an increase in income inequality between the mid-1980s and the mid 1990s such that Gini coefficients of inequality in the OECD's thirty-four developed countries of 2010 showed New Zealand to be ranked down at twentieth (Rashbrooke, 2013 pg., 23). With respect to pre-tax income figures from Inland Revenue with respect to 2002-2011:

> Half of the total population earns less than $24,000. Among them

> are beneficiaries: those on the unemployment benefit receive $11,900 a year before tax, someone on the domestic purposes benefit (DPB) gets $17,300, and pensioners receive $20,800 each... 70 per cent of New Zealanders earn under $43,000. A full-time minimum-wage salary, for example, equates to $28,600 a year (Rashbrooke, pg., 20).

Further up the income ladder:

> 90 per cent of New Zealanders earn less than $72,000. Senior firefighters earn no more than $57,000 a year, while the basic maximum income for teachers is $73,000 (Rashbrooke, pg., 20).

And for those amongst the top 5 per cent of our population:

> The remaining 5 per cent - the highest earning New Zealanders - earn a minimum of $93,000 each. The top 2 per cent earn over $131,000, including MPs, on a minimum of $141,800 as well as chief financial officers and principal accountants. To be in New Zealand's top 1 per cent you would have to earn over $170,000, while the top 0.4 per cent (some 13,000 people) earn over $250,000 each. In this latter group are the most senior managers in government departments and public sector bodies (where more than 250 staff are on over $250,000 each), and the highest-paid staff in large companies, where the average salary for chief executives is $1.5 million. (Rashbrooke, 2013, pg., 20).

Rashbrooke also describes how New Zealand's net wealth (how much people owe in cash and assets, once money is subtracted) is distributed. New Zealand has 2.9 million adults who collectively own almost $470 billion dollars.

> Of that, the top 1 per cent of the adult population own 16 per cent of the total wealth... That's just under $77 billion owned by around 29,000 adults. This group and the rest of New Zealand's wealthiest 10 per cent own over half the country's total wealth. For many New Zealanders in the lowest 50 per cent, the picture is not one of wealth but of debt: the 200,000 poorest (in wealth terms) *owe* a combined $4.7 billion. No one in the poorest fifth of New Zealand owns more than $6,000 in assets. The typical household has a net worth of just under $70,000. Between them, the entire lower half of the country's adults, some 1.45 million people, own just 5 per cent of all wealth, around $23 billion. In other words, the wealthiest 1 per cent of New Zealanders together own three times as much as is owned collectively by the poorest 50 per cent of the population. Rashbrooke (2013, pg., 21-22).

The Statistics we have are also likely to be biased and the actual situation is likely to be one of even greater inequality.

> One gap [in our knowledge] is the lack of detailed information on the top 10 per cent of incomes (especially the top 1 per cent), including the composition of those incomes and how they have been earned. No country has a complete record of top incomes, which are difficult to sample accurately and can be obscured by tax avoidance. In New Zealand, for example, family trusts are used to avoid an estimated $300 million in tax each year. But New Zealand has less data than many countries, because we do not tax or record capital gains (Rashbrooke, 2003, pg., 23-24)

The picture is one in which:

> around 800,000 New Zealanders [are] below the poverty line... And

> against these figures can be set the 29,000 people who hold 16 per cent of New Zealand's wealth or the 13,000 New Zealanders who have incomes over $250,000 (Rashbrooke, 2013, pg., 6).

Let us now turn from inequality of income and inequality of wealth, back to the inequality of mortality, or health. The Commission on Social Determinants of Health (2008, preamble) told us, back in 2008 that:

> The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

This well-known relationship between (on average) more wealth and better health (or less wealth and less health) is standardly known as the 'socio-economic gradient of health'. Sometimes people try and obscure things by saying we don't know whether poor health causes poor wealth, or whether poor wealth causes poor health, but it seems fairly intuitively obvious that they would be mutually reinforcing. We can consider that in New Zealand:

> Around a fifth of poor households report going without several essential items, such as having a decent pair of shoes, heating all the rooms in their house, or giving birthday presents to their family. In half of poor households, food runs out because there isn't enough money at the end of the week. Low-decile schools report many children coming to school without being properly fed, or without adequate clothes - again, because their parents, even when working, don't earn enough to pay for these basic necessities (Rashbrooke, 2013, pg.7).

One doesn't need to do a degree in Public Health to know that this level of poverty is going to impact negatively on peoples health and wellbeing. On their self-esteem and sense of competence in the world. On their mood and on they ways they are likely to contribute to their neighbourhood. In an attempt to quantify basic necessities we hear how a typical two-parent family, with two children, living on one minimum wage income would do, in 2012:

> [A] full-time minimum wage salary of $540 a week becomes $460 after tax. Working for Families and the accommodation supplement might increase that to $790. An average house in eastern Porirua, one of New Zealand's cheapest suburbs, costs $255 to rent, leaving around $540... Feeding a two-child family well - by meeting nutritional guidelines in the cheapest way possible - costs around $260, even if families buy raw ingredients (rather than packaged meals), and the cheapest meat, fruit and vegetables. That leaves around $280 per week for everything else. Running a car (a necessity for many people to access work) typically costs $85. Power costs can often be $50. So once bare survival is taken care of, just $145 a week may be left for everything else: $5 a day per person to cover clothing, a phone, replacing or repairing appliances, healthcare costs, and so on (Rashbrooke, 2013, pg., 6-7).

This is a working family in New Zealand and it doesn't seem at all unreasonable to conclude that this isn't enough for the most minimal standard of living and that lack of income rather than lack of budgeting is the problem, here. Work alone isn't providing enough for the family to survive without supplementary government 'handouts'. While 'few New Zealanders may live in absolute poverty in Third World terms, we do not live in a third-world country' (Rashbrooke, 2013, pg.,7). Many New Zealanders have been required to borrow significantly more than $1 per day in order to survive, at all (e.g., students). 'There is little evidence that poor people are on average any worse

at budgeting than rich people; they just have less money... Nor it is true that they are poor principally because they have too many kids. Although large families are more likely to be poor than others, the majority of families below the poverty line have just one or two children (Rashbrooke, 2013, pg., 6-7)'.

Now let us turn to the issue of inequality of income and distribution of wealth to the issue of inequality of access to homes that enable people to be healthy. As early as 1863 observers were complaining about slum landlordism in New Zealand, and the inability and unwillingness of governments to intervene to improve housing conditions (Bierre, S, and Cunningham, C (2013), pg., 105). These authors describe how the first Labour Government set up public-private partnerships in 1935 as a state intervention to stimulate the economy by constructing thousands of state houses. These state houses were built wherever workers and their families were needed to provide social services as teachers, doctors, and nurses etc. Not only did this provide high quality, affordable houses for those who needed them, it also set the standard for other housing: the building specifications used for state housing became the norm for the whole industry until at least the 1960s and paved the way for other, substandard housing to be demolished. They relate how in the 1960s state houses formed about 10 per cent of the national housing stock.

In 1988 The World Health Organisation Regional Office for Europe published healthy housing guidelines:

> The purpose of these guidelines is to remind Member States, Ministries of Health and Architecture, policy-makers, environmental health officers, sanitarians, planners, architects, and others concerned of housing hygiene in relation to "traditional" and "new" slum housing. The guidelines are aimed at encouraging administrations to formulate a sound housing policy that helps to solve *basic*

> health-related housing problems and to meet WHO's objective of healthful housing for all by the year 2000. The guidelines will also contribute to the United Nations Harmonization Programme (Economic and Social Council - Economic Commission for Europe) on housing (World Health Organisation, 1988, pg., vii).

The guidelines go on to describe a number of considerations that go into healthy housing including orientation of buildings, open space and density requirements, recuperation from sickness or ill health, privacy, aesthetic satisfaction, work activities carried out from home, rainfall and penetrating dampness, excessive noise and vibration, cockroaches, human intrusion, choice of building components, asbestos, water supply, toilet facilities, storing preparing and cooking food, water vapor and condensation dampness, tobacco smoke, ventilation, vehicular trafific, poisoning from plants and fungi, special housing requirements, children, the elderly, the disabled, persons with movement difficulties, persons with hearing and / or speech difficulties, educational measures. I am belabouring this because it is rather surprisingly common, still, for government officials, and others, to try and have people believe that housing we have known to be substandard for a very long time, is habitable housing. With respect to the purpose of the World Health Organisation guidelines:

> The guidelines are aimed particularly at developing middle-income countries in Europe, defined by the World Bank as Belgium, Bulgaria, Czechoslovakia, Greece, Ireland, Italy, Poland, Portugal, Romania, Spain, Turkey and Yugoslavia. However, the principles of healthy housing have universal applicability as most countries of the developed world have areas of slum or otherwise unsanitary housing. It is hoped that the guidelines will be extensively used as a reference to basic health requirements for new housing and human settlements and as a guide for assessing the hygenic quality of existing housing. It also could be used in interprofessional and

> community education and training programmes (World Health Organisation, 1988, pg., vii).

In New Zealand it was around this very time that instead of the government investing in improving housing quality (e.g., by installing central heating and ventilation systems) state houses were sold off to private investors such that:

> In 2006 this stock now forms less than 5 per cent of the overall housing stock and is among the smallest in the OECD. This is considerably less than 20 per cent in the UK or levels in Switzerland, Germany, Austria, and Sweden where the majority of renting population rent from social, or not for profit landlords. (Bierre and Cunningham, 2013, pg., 165).

Bierre and Cunningham describe how, now in private hands, house prices rose faster than inflation, home ownership fell despite most people in rental properties preferring to own their own home for security and as a means of improving the quality of their housing. With respect to quality of housing:

> Our housing standards were essentially set by the Housing Improvement Regulations of 1947; extraordinarily, these still apply today. Two-thirds of our current housing stock was built before insulation standards for new buildings were introduced in 1977 after the first oil shock. And even these very minimal regulations of existing dwellings have been poorly enforced; local councils site a number of reasons for their inaction, such as few alternatives for occupants of poor housing, a lack of resources and unclear legislation. Light-handed building regulation from the 1990s onwards has not improved matters; modern buildings are thus likely to have their own set of quality issues, alongside those manifested in older

> buildings. Inadequate regulation and enforcement of housing standards coupled with high rates of deferred maintenance, have led to serious problems in the quality of New Zealand's housing stock overall. Older rental accommodation is in the poorest condition; over 50 per cent of renters reported one or more major problems with their dwelling compared to 28 per cent of owner occupiers. Over two-thirds of children are living in poverty... Perhaps unsurprisingly, New Zealand is seen internationally as having notably poor housing standards - a genuine outlier in the developed world (Howden-Chapman, Bierre, and Cunningham, 2013, pg., 113).

It was not the case that landlords invested in improving the quality of their housing. They sat on the housing and profited from people paying them money to live in their slums. In New Zealand Poor quality housing and overcrowding has been described as leading to:

> [A]ppalling rates of what are normally considered Third World diseases, especially among children: meningococcal disease, rheumatic fever, cellulitis, bronchiectasis and childhood pneumonia... While other developed nations have reduced or virtually eliminated these diseases... in the two decades after 1989, the New Zealand rate of admissions to public hospitals for infectious diseases increased strikingly by 51 per cent - equivalent to 17,000 additional hospitalisations. The risk of admissions for infectious diseases was more common among people with Māori and Pacific ethnicities and those living in areas of relatively high poverty.

Rashbrook describes how:

> [D]eep poverty has long been a crisis for New Zealand, one confronted by many committed researchers, campaigners and organi-

> sations. [New Zealand has] one of the world's worst records of child health and well-being with alarming rates of preventable diseases amongst children. Children in New Zealand are more likely to be poor, and less likely to feel safe and well, than children in most other developed countries. One major report on children's welfare ranked New Zealand twenty-eighth out of thirty developed countries, better only than Mexico and Turkey. In particular, our rates of preventable diseases, especially among children and the elderly, have been described as a 'national embarrassment" (Rashbrooke, 2013, pg., 2).

While there have recently been some alterations to building legislation around ceiling and under-floor insulation requirements on wall insulation are lacking and houses are not required to have double glazed (and pressure sealed) windows, thus still allowing for heat to escape from the house via the weakest link. We are currently positioned such that getting landlords to install a single heat pump for a property (as a chattel source of heating for the property rather than as a source of heat that must be purchased and maintained by tenants) is seen as an unrealistic ideal. It is known to many, however, that installing a single heat pump is not able to heat a house to temperature. This is why central heating systems have a central source of heat - a water tower or a heat pump - linked to a series of radiators that are installed in every room. It has been pointed out that many landlords live in houses that do not have central heating and many landlords choose not to heat their bedrooms at all. In response, there is all the difference in the world between choosing to live like that, and being forced to live like that. There is also a difference between people who spend much of every day working in climate controlled environments and spending little time at home from people who spend around 90 per cent of their time in their home. Building legislation in New Zealand still falls far behind building legislation in other developed nations. New Zealand building

legislation is still a case of too little, too late. Our legislators have not stepped up to the plate, yet.

2.2 Future inequality

Instead of considering inequality at a snapshot in time, we can get a sense of the overall trajectory by considering how it has progressed through time. The best prediction we can make for the future is based on knowledge of the past.

2.2.1 Between countries

The issue of inequalities between countries is complicated to assess and I won't have much of anything to say about it here. Generally, the idea seems to be that developing nations are doing just that and that their development involves their more closely approximating the status or standing of other nations. Perhaps as their military comes to be feared, or as their technology allows them to develop more desirable products. Sometimes the focus is on the wide spread availability of consumer items that were once available only to a select few. Cars, for example, air travel, televisions, personal computers. Whether the later constitute progress in equality when the status is more that of the end of the supply chain (for example, the cars that are near the end of their useful life, or other consumer products who didn't manage to be sold in any of the countries they passed through on their way here) is unclear, however.

There is evidence that New Zealand is falling behind the developed world.

> The last thirty years have seen a market shift in power and rewards away from ordinary workers to owners and managers... despite their protestations to the contrary, companies, company owners and their managers face few constraints on their ability to per-

> form in one of the easiest economies in the world in which to do business. Contrary to the arguments presented in the 1980s and 1990s... this shift in power has not driven strong growth and improved productivity. Once, New Zealand enjoyed one of the world's best standards of living, but in recent decades we have fallen further and further behind other developed countries, and we are now twenty-first out of the thirty-four OECD countries when it comes to income per person. Our productivity performance is also equally poor (Haworth, 2013, pg., 198-199).

Apparently this is part of the ideology that was embraced by our nations leaders:

> The reason we are doing to badly is that our policy-makers, and most of our investors, have chosen what is internationally known as the 'low road' to growth. The dominant business model has focused largely on controlling and cutting costs, on the basis that this would, eventually, lead to greater economic growth. Levels of government intervention and regulation have been kept low, and, above all, most employers have preferred to use a 'low-wage' model in tune with the 'low-road' approach to growth, a choice consciously supported by employment legislation in the 1990s and again since 2008. The result has been a weak economy, stuck in the 'low' end of the economic performance spectrum. Large numbers of low-paid, low-skilled workers are, for the most part, involved in the production and export or basic, low-value commodities; or in an underperforming and unloved manufacturing sector; or in a service sector marked by low skills, low levels of training and low pay. In addition, the low level of input that most staff experience in their company's decision making means that their ideas, talent

> and innovation often lie unrecognised and unused (Haworth, 2013, pg., 199-200).

Also that:

> In New Zealand, the share of economic growth going to wages and salaries has been declining internationally since the 1980s... These changes have been driven by a philosophy that assumes that we must first generate economic growth, and then wages may be able to rise... Many now believe that it works the other way around... In this view, salary and wage rises contribute to increased growth, because - to put it simply - better-paid employees work smarter, are more productive, generate more profits, and higher wages, and consume and save more (Haworth, 2013, pg., 201).

In other words, the view here is that our gross domestic product is lower than it would be if we paid, housed, educated, employed and basically allowed more of our people to live more in keeping with their potential. Instead of being kept in unsanitary living and working conditions for the supposed good of some elite minority who chooses to sacrifice others for their own personal advantage.

Gould, writing in 2010 (about why New Zealand should be reluctant to sign up for the TPPA since we aren't being offered much since we have little to bring to the table except for increased dairy exports which would undermine local producers of other nations) states, along similar lines:

> The classic instance of a country seeking to step up to the economic mark is that of a developing economy. If we look to Japan and Korea, and now China and India, which have all been developing economies over relatively recent times, we can see that they all chose to protect their economies behind tariff walls and other

> obstacles to free trade... The Japanese economic miracle of the 1960s and 1970s was built on that basis; the Chinese version is similarly based today. Although New Zealand does not see itself as a developing country, it should do. Many of the countries that New Zealand has traditionally regarded as developing are now outperforming it by comfortable and growing margins. It would be helpful for New Zealand to identify itself correctly, not as a developed country and only perhaps as a developing one, and to frame its economic policies accordingly. (Gould, 2010, pg., 38).

2.2.2 Within New Zealand

While I tried to keep the first section as more of a snapshot view, it did turn out to be more of a story of progression. Rashbrooke, (2013 pg., xi) more explicitly states that the trajectory of inequality in New Zealand is such that the gap between high and low incomes has widened faster in recent decades in New Zealand than it has in most other developed nations.

> New Zealand now has the widest income gaps since detailed records began in the early 1980s. From the mid-1980s to the mid-2000s, the gap between the rich and the rest has widened faster in New Zealand than in any other developed country (Rashbrooke, 2013, pg 1).

The sale of state owned state house assets:

> shift from state to market provision created a growing gap between those who owned houses and those who did not. The increasing consumer price inflation of the 1970s and 1980s, combined with rising real mortgage interest rates of the 1980s onwards, made it

> more difficult for those who were renting to buy houses, adding to the value of home ownership. (Howden-Chapman, Bierre, and Cunningham, 2013, pg., 110)

More recent statements on the situation in New Zealand include increasing mainstream media attention. In an article entitled 'outrageous fortune: what skyrocketing executive pay means for inequality' the New Zealand Listener reports a situation of rising inequality:

> The salary paid to the boss of the Ministry of Education, for instance, increased 56% between 2004/05 and 2015/16, from a band of $410,000-419,999 to $640,000-649,999. By comparison, the top base pay rate for teachers has increased 25% from $59,537 to $74,460 over the same period... At the Ministry of Health, the chief executive's pay has gone up 28% in the same period, from a band of $390,000-399,999 to $500,000-509,999.

The New Zealand Herald reports 'DHB bosses and board members cost taxpayers $65 million a year':

> Taxpayers forked out almost $66 million last year to pay 444 people to run the country's 20 district health boards. The bulk of that money, up to $60m, pays for 231 chief executives and their senior executives while 209 board members and four commissioners are paid almost $6m for just 30 days of work each year... At Southern DHB the board was sacked by then Health Minister Jonathan Coleman in mid-2015, because of progressively worsening deficits projected to be as high as $42m. Commissioner Kathy Grant was appointed to tackle the deficit and is being paid $1400 per day to steer the DHB back into the black by 2019. Her three deputies, Graham Crombie, Richard Thomson and Angela Pitchford are paid

> $900 per day each, plus expenses. Last year Grant, Crombie and Thomson were forced to apologise to prostate cancer patients who waited so long for treatment their life expectancy was shortened. The DHB was so far behind its cardiac surgery schedule that one patient's operation was cancelled six times. Another patient whose surgery was cancelled four times died. (New Zealand Herald, 2018)
> .

On the other hand, nurses strike over 3 per cent pay offers and:

> Jaine Ikurere, the 63-year-old woman who cleans the Prime Minister's office, is still on just $14.60 an hour after 19 years of cleaning at Parliament. (Rashbrooke, 2013, pg. 9).'

While there has been an increase in minimum wage since then, it is worth comparing that increase in minimum wage with the increase in chief executive wages in the corresponding time period. It seems that the trend has been that inequality is increasing, and projections are that it will continue to do so, into the future. This isn't something restricted to New Zealand. Let us consider how the Kaiser Family Foundation 'Focus on Health Care Disparities key facts (2012, pg.,3, 7)' document reports US census projections from 2008 to apply to an increase in inequality in the US population 2000-2050:

> It is projected that people of color will account for over half of the population by 2050, with the largest growth occurring among Hispanics... Moreover, the gaps between the richest households and poor and middle income households are wide and growing in most states, with the richest 5% of households having an average income of $272,500, 13 times the average income of $20,000 for the bottom 20% of households. Given that people of color make up a disproportionate share of the low-income and the uninsured relative to

> their size in the population, the growth of communities of color and widening of income gaps amplify the importance of addressing health and health care disparities... [Also that:] Disparities limit continued improvement in overall quality of care and population health and result in unnecessay costs and are increasingly important to address as the population becomes more diverse.

I will have much more to say about projecting or predicting worsening of inequality and precisely that as a mechanism of entrenchment.

2.3 From inequality to inequity

Rashbrooke relates how:

> The argument for reducing differences (in this case, for reducing income inequality) has strong ethical foundations, grounded in the idea that all human beings 'are equal in some fundamental respect'. People's ability 'to participate fully in their society and enjoy a sense of belonging' is especially important. While people have a responsibility to contribute to society, they also have a right to share in the rewards of the society that they have helped create. The roadworker, the receptionist and the rigger all contribute to a functioning economy, just as much as the businessman or the board director (Rashbrooke, 2013. pg.8).

If we now remember Nthabiseng, Pieter, and Sven many of us have the intuition that it is grossly unfair that their individual life chances should be so radically different based on factors such as their nationality, racial group, assigned sex at birth, or the individual was born into a low or high income family. Life is not a game where one gets to choose ones initial personal statistics. One

does not get to choose where one will be born, what race one will be, what socio-economic class, or, indeed, whether one will even be born, at all.

With respect to inequalities in income people do have a tendency to lose the intuition that inequalities are (necessarily) unjust, however. For example, if we focus on inequality of pre-taxation income then the counter is that some people deserve to earn more than others because they either a) work harder than others so deserve more remuneration and / or b) have the ability to do highly skilled things that most people cannot, so deserve more remuneration.

In response to this, we can agree that people who a) choose to take on extra work (when others decline to take on extra work) should be remunerated for it, and that b) people who have the ability to do things that most people cannot (even though other people similarly had the opportunity to work to develop their talents and skills) should be remunerated more for it. The issue is one of inequality when others didn't have equality of opportunity to take on the work (e.g., because their application is not processed and / or because the work is not offered to them, perhaps due to discrimination against them), or to develop their talents and skills (because they do not have access to quality schooling or structured after-school activities) such that they could competently take on the work.

Ian Taylor (a chief executive) relates:

> [W]hen large amounts are being paid to some, and the family down the road is not able to feed their two or three kids... that inequality just seems wrong, and it doesn't seem to make sense. It's pretty basic.

People have claimed that we need to pay our top (particularly government) people well or they will take off to earn more in the private sector, or to earn more overseas. Despite this the State Services Commission reports:

> The remuneration received by the highest paid Crown entity CEs is too high... There are important guiding principles that underpin the role and function of the State sector which are relevant to chief executive remuneration. Once of those principles is the spirt of service, a duty to act responsibly in the public interest and to be a good trustee of public resources, including remuneration. The second principle is around public trust, an expectation that the State sector is accountable, transparent, fair and reasonable... CEs need to be paid fairly, at a level sufficient to attract and retain the best people, but we also need to be fair to the taxpayers who pay the bill. (State Services Commission, 2017 pg.1)

Taylor maintains:

> [H]igh pay is not even a sensible motivator, Taylor adds. 'If you have got people running companies whose focus is on the size of their pay packet, then I don't think they should be running them... One can refuse to take pay increases. Putting a lid on salary increases is an obvious first place to start'.

If people only want to take on high level positions in our government, universities, and hospitals because of the remuneration - or, what the job can do for them, then they probably are not the best people for those jobs. It is implausible to think that, in the majority of cases, the people filling those positions are taking personal financial hits to fill those positions. It is far more plausible to think that, in the majority of cases, these individuals are simply pursuing the best financial package the can, for themselves, which (given current pay structures) has them placed in the positions they are in. If politicians were paid less, for example, then we would have the opportunity to see more people take those roles who are interested in them not for what the roles can do for them, but more for what they can do for those roles. Providing a financial

incentive for those roles is the most effective way of crowding out people who aren't driven by financial remuneration.

If we try and find some sort of common-sense understanding of 'equity' then we will find something along the lines of the following:

1. Fairness or justice in dealings between persons
2. A system of law dealing with (for example) succession, trusts, or inheritance of asset.
3. The value of an owner or shareholders interest in a property in excess of claims or liens against it.

There is an extensive literature on the first of these notions in moral and political philosophy, and in philosophy, politics, and economics. Equity is linked to notions like justice or fairness and the issue of 'why be equitable?' is something interpreted as being a question along the lines of 'why be moral?'. This is to say that if one doesn't understand that equity should be a consideration, then one doesn't understand what it is to be moral. It is often described as having something to do with the way resources are distributed on grounds of justice or fairness. For example, 'you cut and I choose' is an equitable or fair rule because following it is likely to lead to an equitable or fair distribution. 'I cut and I choose' is a less fair rule, however, where equity or fairness relies on individual conscience, or a sense of morality. This is something I have come to see appears to be lacking in many people - if they think they can get away with taking more than their share they think they would be a chump for having passed up the opportunity.

Equity also has a tradition in law, where equity courts – chanceries – were set up to deal with making judgements on cases where the laws were commonly regarded as insufficient for judges to make rulings in the interests of equity or

fairness. For example, the traditional laws didn't allow judges to make rulings that seemed fair about the distribution of inherited asset or property.

Equity also has a tradition in financial accounting where the basic financial equation states that equity is the remainder of the difference between assets and expenditure. Owners or shareholders equity has to do with the capitol of the company and how it will be distributed in liquidation. While the legal and accounting notions are typically thought to be distinct from the notion that is relevant to health and healthcare they might turn out to be of use yet with respect to our understanding succession in Medicine and the growth of various health-related businesses in ways that are (in the first sense) equitable between persons.

It would be a fairly standard view to think that it is the first sense that is relevant, here, and move on from the other two ideas as not being relevant. I think that these three notions of equity are important, however. Later, we will see that it is worth asking who the primary beneficiary of a proposed equity intervention is. More particularly, whether an intervention done in the name of equity is more likely to empower the equity group, or whether the intervention is more likely to entrench inequality. In order to assess this we need to be very clear on who the equity group - or primary beneficiary is supposed to be. When we are considering equity we need to bear in mind that different players might be using the terms in different ways, or perhaps even being ironic, intentionally ambiguous, or even intentionally misleading.

2.4 From inequity to equity group targets in New Zealand

We have just seen how a focus on 'equity' in one sense(?) is, simply a focus on the wealth. Not necessarily on issues of distribution. When it comes to identification of equity groups, however, the primary 'equity' groups are those who have been identified as the victim or target of inequity, however.

All the way back in 2008 Signal, Martin, Cram, and Robson produced *The Health Equity Assessment Tool: A User's Guide* for the Ministry of Health. They identify what they regard to be 'types' of inequality: ethnic, gender, socioeconomic, geographical and disability (Signal, Martin, Cram, and Robson, pg., 10). I will consider each of these groups in more detail in chapter 4. They also ask us to identify (among other factors) what inequalities exist, who is most advantaged and how, and then the issue of how the inequality occurs, or what the causal chain is that leads to the inequality. For example:

> HEAT seeks to identify who is advantaged in relation to the health issue being considered and in what ways this advantage plays out. The focus is deliberately on who is advantaged or privileged, rather than on the 'victims' of inequity. A focus on 'victims' risks locating the origin of inequity in the supposed deficits and failings of individuals rather than in the social institutions and practices that have caused the inequity. A focus on who is advantaged, on the other hand, examines the unearned privilege that some groups have acquired as a result of inequalities (Signal, Martin, Cram, and Robson, pg., 10)

The ask us to consider:

> How did the inequalities occur? What are the mechanisms by

> which the inequalities were created, maintained or increased? This question focuses on how inequalities have occurred and therefore what needs to change for them to be addressed. (Signal, Martin, Cram, and Robson, 2008, page 10)

They also consider a hypothetical causal chain: belonging to a marginalised group > discrimination − access to education > educational attainment − employment status > income > access to health care. (Signal, Martin, Cram, and Robson, 2008, pg., 11).

This idea of focusing on the primary beneficiaries is a very interesting one. It is interesting that 'equity' groups are groups who have been identified as victims of the negative end of the inequality. I think it is important that we be clear on the valence. I will have much to say about who the primary beneficiaries are throughout this thesis. It is a very interesting idea to focus on who is the recipient of unearned privilege who stands to (continue to) profit if we fail to intervene to rectify the injustice.

With respect to being clear on valence we can reword their hypothetical causal chain to: belonging to a marginalised group > discrimination > lack of access to education > lower levels of educational attainment > lower employment status > lower income > less access to health care > lower levels of health. Let us consider: Who profits - or, who is the primary beneficiary of this situation?

When the state owned houses were sold off to private investors, to be rented at market rates (thus making housing more unaffordable for people) who brought up the state owned houses? The Register of Pecuniary and Other Specified Interests of Members of Parliament (2018) states that 32 MPs are declared residential landlords owning 59 residential properties between them. We are not told how many high level government employees in health and universities have similarly chosen to invest in private property rentals as a way of spending the net income the government hands out to them to invest in the market.

When the government refuses to tax capital gains and refuses to bring our building (housing) legislation into line with building (housing) legislation in other developed nations we should ask who profits? In Changing the Rental Rules (2017) Hargreaves describes how landlords don't want to install heat pumps that make heating more affordable for their tenants because their tenants can't afford to pay more rent than they are already paying. Landlords can't turn a greater profit on making their houses healthy for their tenants, they turn greater profit from being slum landlords - and there are no building regulations preventing their doing so.

When the government refuses to legislate to limit the number of tourists and international students such that there are enough houses not only for tourists and international students but New Zealanders, also; when this drives up the demand for housing so landlords can increase rental rates, and New Zealanders further can't afford healthy homes - who profits? Calling them refugees instead of tourists or students doesn't fundamentally change things (though refugees might be thought to be more desirable insofar as they are likely to complain less). The issue of tourists or students is related to the issue of the quality of our housing. Housing that is built specifically for tourists or students is only supposed to be temporary. It was in the name of tourist or student accommodation that we ended up with large slum boarding house / cheap motel style accommodation with, for example, no balcony space in high rise apartments, and a proliferation of accommodation that would be considered too small and lacking in basic amenities for full time habitation (such as providing secure food storage space or ventilated cooking areas). New Zealand has ended up with a proliferation of slum building infrastructure that was 'only supposed to be temporary' - for tourists or students.

One should be concerned about who is investing in private hospitals / aged care facilities because these people have financial incentive for public hospital and health system infrastructure to not be maintained. These people have

financial incentive for the demise of the public health system to further their own, narrowly conceived, financial interests. How do the chief executives and members of the board choose to spend their money in the market?

The argument against us bring our legislation more into line with the legislation of other developed nations has been a retort that we don't want to interfere with the free market. The market is not particularly free for the majority of New Zealanders, however. We are forced to buy the cheapest possible (end of the supply chain crap) because we cannot even afford to pay rent to live in our houses. Before we considered Nthabiseng, Pieter, and Sven. Let us now say what Karlo has to say about what she has seen of life in New Zealand:

> People with limited resources are forced to 'choose' less than optimum options by default, through lack of knowledge, resources, time, local facilities, or power. It is what happens when you can't afford a car and all the shops within a walking radius sell cheap liquor, pokies, five different types of deep fried food, and no fruit and vegetables. It is what happens when the schools around you serve up an accent to your five year old so that he sounds like Jake the Muss from *Once Were Warriors* and learns not to make eye contact with adults, rather than numeracy and literacy. It is what happens when he comes home and asks you why he has a black face. It is what happens when you don't feel safe walking down your streets unless you have gang protection, and four out of five of the older boys, brothers and cousins you admire, are already finding that this is the only sphere in which they shine, where they are respected, accepted and recognised as powerful and productive.
>
> It is what happens when the real banks won't lend you money and the loan sharks are wooing you, cheap bait for bad debt. And when no one you know actually owns their own house, or knows what

> a PhD is, or has plans for their future. And most of your time is spent making sure that you can get food on the table and that the power won't get cut off; and you know there is no money for extras like Saturday sport for your talented kids because you can't afford boots or fees, no swimming lessons, and no class photos, and no Lucky Book club books; and your children already know that there are things in life that are beyond their reach, that are not for them, and they are already feeling it in ways that make them burn inside. This is not about options: This is about making the best of bad situations, and survival... How do these children present themselves creditably to our society without the shame and stigma of identifiable poverty, further compounded by ethnically marked bodies? How do they ward off the pain of shame and humiliation? How do they grow up feeling good about themselves and society, and hopeful for their futures? (Mila, K (2013), pg., 87-88).

The above is a lengthy quote - spanning 2 paragraphs - but I provide it, here, because it articulates a situation eloquently, in a way that is likely induce empathy in the reader. I will refer back to this quote in the last chapter when I consider how young adults of a certain demographic may be likely to be judged by people outside that demographic. In New Zealand in 2008 Howden-Chapman and Bierre stated that we weren't sure whether sub-standard housing causes ill-health, or whether ill-health causes people to live in substandard housing. Similarly, we werent' sure whether poor people had more ill-health because they were poor, or whether it was people who suffered from ill-health who were poor (Howden-Chapman, P and Bierre, S (2008), pg. 161). They state:

> [C]hildren born into low-income households will have more illness and shorter lives, on average than those born into high income households. But why is this so? Do lower incomes buy less healthy

> housing, and do these less healthy housing conditions partially explain the difference in life chances? And, if differences in housing quality are part of the answer, is it possible to identify research-based housing interventions that can reduce these health inequalities?

And, of course, it turns out that the 2008 report wasn't really asking who profits from the lack of government intervention, as I have asked, above. It turns out that the 2008 report had more in mind the idea that throwing a little money at Māori to run a 'smokefree' campaign would benefit Māori. The report didn't explicitly say anything at all about how throwing a little money at Māori to run a'smokefree' campaign was less likely to benefit Māori (and more likely to benefit big tobacco) than a stronger government legislative intervention could have been. We are told the HEAT strategy can not only be used to justify future government interventions, but also it can be used in hindsight to justify what has already been done. We are also given the usual on how we don't know what interventions may be effective so we will just have to sit back and wait (or throw a little money at university researchers) in a manner that mostly continues to benefit those who are benefiting the most, already. We don't know about the housing situation: Let us sit back and watch several generations of Pacific Islanders develop rheumatic fever -¿ not be given antibiotics (they wouldn't take them properly anyway) -¿ development of systemic immune response attacking heart valves -¿ lack of valve replacement operations -¿ strain on heart -¿ lack of heart transplant operations -¿ heart failure. While we might be campaigning for greater awareness of such things now (and equitable access to anti-biotics) we have still not fixed the overcrowded housing situation or improved it such that adequate heating allows members of a household to disperse through the space rather than congregating in a single room because it is cold.

The Socioeconomic gradient of health 'does not have to be that way and it is

not right that it should be like this. Where systematic differences in health are judged to be avoidable by reasonable action they are, quiet simply, unfair. It is this that we label health inequity. Putting right these inequalities - the huge and remediable differences in health between and within countries - is a matter of social justice. Reducing health inequities is, for the Commission on Social Determinants of Health (hereafter, the Commission), an ethical imperative. Social injustice is killing people on a grand scale (Commission on the Social Determinants of Health, 2008, preamble).

More recently there has been a growing awareness of these issues around unaffordable, unhealthy housing. This chapter has been hard to write because I have been wanting to assert the obvious and then move on. The problem is that when we look at who profits (and how much they have been profiting from the status quo) we can better understand the immense resistance there has been (the confusion in the literature that has been created) all the people whose livelihoods have been dependent on receiving government handouts to obscure relationships that were obvious all the way back in the 1800s and in the 1980s World Health Recommendations on Healthy Homes. We are told that more sociologists, particularly, and journalists (such as Rashbrooke) have succeeded in articulating (and facilitating others articulation of) the issues so that this chapter doesn't have to be my whole thesis. We are told that with respect to narratives (such as Mila's above) Bierre and Howden-Chapman describe in an abstract how:

> while narratives used by advocates for policy change were effective in raising the issue, they were ineffective in overcoming a counter-narrative of excessive regulation by the government and concerns of possible rent rises. This opposition to regulation of the private sector by a right-leaning government needs to be more effectively countered by more powerful intersecting narratives, if evidence on the relationship between housing, health and safety is to become

the basis for effectively implemented government policy.

The idea expressed in this above quotation is that the standard response to concerns that people have had about unhealthy housing have been met with the view that bringing our regulation into line with building regulation in other developed nations would be 'excessive'. Also that if landlords were required to provide quality heating infrastructure as chattels (e.g., central heating - though usually the focus has been on a single heat pump sufficient to heat a single room) then landlords would pass the costs on to tenants which would make housing even more unaffordable.

In response, we have seen already how inequality is increasing in New Zealand at a faster rate than it is in much of the world. This is because the New Zealand Government has failed to legislate to protect it's people comparably to the governments of other nations. While it is the case that there are people who have borrowed extensively to become landlords because they were promised returns on their investment that required them to maintain slums we need to appreciate that other landlords have been making exorbitant profits at their tenants expense.

The counter-narrative is one that is not responsive to reason. The counter-narrative is being generated by the primary beneficiaries of the status quo and they seem to regard their job as one of ensuring that there is no legislation that puts the people of New Zealand ahead of the interests of some elite minority both in this country, and overseas. While the call has been to appeal to people more widely - an alternative is to appeal to people more reasonably. To stop attempting to dialogue with those who will not hear reason and who are disingenuous when it comes to their unwillingness to respond reasonably and humanely to causal chains that are known well enough for them and their cronies to have decided to invest in profiteering from.

New Zealand has been described as being the best place in the world in which

to do business, and particularly in which to start or set up a business 2016, 2017 (The World Bank, 2018).

> The foundation of *Doing Business* is the notion that economic activity benefits from clear and coherent rules: rules that set out and clarify property rights and facilitate the resolution of disputes. And rules that enhance the predictability of economic interactions and provide contractual partners with essential protections against arbitrariness and abuse. Such rules are much more effective in shaping the incentives of economic agents in ways that promote growth and development where they are reasonably efficient in design, are transparent and accessible to those for whom they are intended and can be implemented at reasonable cost. The quality of the rules also has a crucial bearing on how societies distribute the benefits and finance the costs of development strategies and policies (The World Bank, 2018, pg12).

We are told:

> The design of the *Doing Business* indicators has been informed by theoretical insights gleaned from extensive research and the literature on the role of institutions in enabling economic development... The choice of the 11 sets of *Doing Business* indicators has also been guided by economic research and firm-level data, specifically data from the World Bank Enterprise Surveys. These surveys provide data highlighting the main obstacles to business activity as reported by entrepreneurs in more than 131,000 companies in 139 economies. Access to finance and access to electricity, for example, are among the factors identified by the surveys as important to businesses... Some *Doing Business* indicators give a higher score for more regulation and better-functioning institutions (such as courts

> or credit bureaus)... Thus, the economies that rank highest on the ease of doing business are not those where there is no regulation - but those where governments have managed to create rules that facilitate interactions in the marketplace without needlessly hindering the development of the private sector... (The World Bank, 2018, pg., 12)

It isn't just that our government has refused to legislate for the people. It is that our government has legislated in the interests of business - against the interests of the people. As we have seen it is also the case that members of the government have chosen to personally invest in rental properties and thus have a vested interested in protecting their investment.

There are many examples of experiments (or observational studies) that have been targeted towards people of certain groups. For example, Nazi concentration camps (where many experiments and observational studies were performed were targeted towards people with disabilities, Jews, and Gypsies for the supposed benefit of the Aryan peoples. The Tuskagee Study of Untreated Syphilis carried out by the US Public Health Service, in collaboration with Tuskagee University (an historically Black college) enrolled 622 impoverished African Americans in order to observe the progression of untreated Syphilis in 431 of them - without informing them of their condition, or of the fact that they would never be treated despite growing evidence of the utility of penicillin (Brawley, 1998). In New Zealand we may wonder whether Māori and Pacific peoples have similarly been targeted for observational studies of untreated infections resulting from living in housing conditions known to be unhealthy. For how many generations are we going to sit by and watch the obvious unfold? We know it is obvious because of how people have chosen to invest (tie their wealth) to this likely future. It is disingenous to suggest that we don't have enough information and recommend that we sit back and watch / fund another observational study:

> Although we are gaining an increasingly nuanced picture of health inequalities and engaging in more sophisticated debates that extend our understanding of the causes, there has until quite recently been less concentration on the practice of intervening to reduce these inequalities... Part of the challenge here is that there is very little empirical evidence from activities which have an explicit focus on reducing health inequalities either in terms of effectiveness or in terms of the theories of intervention. Where there is, the quantitative evidence of effectiveness is often equivocal, with calls for greater concentration within the literature on understand more about the connection between individuals and societal structures, as well as a greater understanding of social complexity generally (Matheson, A and Dew, K (2008) pg. 14-15).

It was after the 1980s World Health Organisation report on Healthy Housing (which provides something of a recipe for all the things that should go into the development of unhealthy housing) that many State Houses were sold off into the private sector such that New Zealand came to have lower rates of State Housing than other developed nations. We should ask ourselves how many politicians decided to personally invest in the purchase of State Owned Asset Sales, in New Zealand, with the intention of profiting from slum landlordism. Politicians did nothing to improve building legislation so more people could enjoy healthy homes. Instead, landlords profited at the expense of their tenants. Currently, housing legislation seems to be improving, though not enough to bring us into line with other developed nations. Landlords have made their fortune enough to invest in boarding houses or aged care institutions or private hospitals and we see an increasing amount of private rentals up for sale in recent years.

We know intervention has the power to change things:

> the recent Healthy Housing Programme, formerly operated by Housing New Zealand, found that when state houses were extensively refurbished and joint efforts were made by housing officers and visiting nurses to improve families' living conditions and healthcare, hospital admissions for children fell by two-thirds (Howden-Chapman, Bierre, and Cunningham, 2013, pg., 117)

We hear that the trajectory of inequality is such that 'the patterns of health inequalities are not fixed and immutable, suggesting that with will and determination, alongside better understanding of both the underlying mechanisms that cause health inequality and the interventions that can redress them, a more equitable society is achievable (Matheson, A and Dew, K, 2008 pg. 12).

In the face of little change we should ask: Who profits the most? Or, we should ask ourselves who the primary beneficiaries are. In *Strategizing national health in the 21st century: a handbook* Schmets, Rajan, and Kadandale (eds) report that:

> In the 2016 WHO report Public financing for health in Africa: from Abuja to the SDGs, WHO concluded that "for every USD 100 that goes into state coffers in Africa on average USD 16 is allocated to health, only USD 10 is in effect spent, and less than USD 4 goes to the right health services" (Schmets, G, Rajan, D and Kadandale, S, 2016, pg. 9).

We may well wonder for every dollar of New Zealand taxpayer's money that goes into funding our Public Health System - how much of that is spent on the 'right services'.

In this chapter I have introduced the notion of inequality (of income, wealth, and health). I have provided some evidence that New Zealand is doing badly on both counts: At generating wealth (compared to other developing nations) and

at distributing that wealth equitably amongst it's people. I have provided some evidence that the projections are that inequality in wealth in New Zealand is increasing and we are seeing a greater and greater division between the have and the have nots in New Zealand, and a greater proportion of us are making it into the have not category as time goes on. I have considered how failure of the New Zealand Government to legislate (e.g., building laws, wage laws, tenancy laws) and policy (e.g., sale of state owned assets especially houses) has contributed to this situation. In the next Chapter I will introduce the United Nations and World Health Organisation as organisations that our government is accountable to. We can then consider the flow of money from government to district health board purchasing of goods and services from the public and private sector.

Chapter 3

From the United Nations to the District Health Board

This chapter will range over a number of themes. It will introduce notions like 'equity' as understood by the United Nations, the World Health Organisation, the New Zealand Ministry of Health, and local District Health Boards. It will introduce the idea of the sleight of hand that gets us from unmeasurable goals like health for all peoples to health outcomes that can be measured, to health targets that should be promoted, to the notion of certain peoples or groups who may be targets for special interventions. We need to understand the context as one in which we are aiming to prevent the recurrence of atrocities such as the Nazi Death Camps that resulted in the extermination of so many people with the disabled, those of Jewish Ancestry / Faith, and Gypsies as targets for the supposed benefit of the Aryan people. Also the Tuskagee observational studies where African Americans were offered free health care by the state but where the untreated progression of Syphilis (and premature deaths) were what those peoples were offered. We need to ensure that similar abuses don't occur in New Zealand and this is why the United Nations asks us to focus on equity and keep statistics to ensure that certain peoples do not bear the brunt of abuses by those in power in the name of 'healthcare' or, perhaps ironically, in

the name of ‘equity’ itself.

3.1 The United Nations

The United Nations was formed around the time of the Second World War. The founding document is the Charter.

3.1.1 The charter of the United Nations

The Charter of the United Nations and Statute of the International Court of Justice was signed by a number of countries (including New Zealand) on 26 June 1945. The preamble sets the context and rationale for the founding of the organisation. The context, or rationale is important because it sets the overarching or dominant goal or purpose to which all else is supposed to promote or contribute towards:

> We the peoples of the United Nations determined
> - to save succeeding generations from the scourge of war, which twice in our lifetime has brought untold sorrow to mankind, and
> - to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small and
> - to establish conditions under which justice and respect for the obligations arising from treaties and other sources of international law can be maintained, and
> - to promote social progress and better standards of life in larger freedom,
>
> And for these ends
> - to practice tolerance and live together in peace with one another

as good neighbours, and

- to unite our strength to maintain international peace and security, and

- to ensure, by the acceptance of principles and the institution of methods, that armed force shall not be used, save in the common interest, and

- to employ international machinery for the promotion of the economic and social advancement of all peoples,

Have resolved to combine our efforts to accomplish these aims

Accordingly, our respective Governments, through representatives assembled in the city of San Francisco, who have exhibited their full powers found to be in good and due form, has agreed to the present Charter of the United Nations and do hereby establish an international organization to be known as the United Nations.

I want to draw the reader's attention to the first two conditions - to prevent war (promote peace and security) and to reaffirm faith in fundamental human rights. More particularly, to draw the reader's attention to the claim that these are preconditions for treaties to be maintained, and also the notion that treaties are a matter of international (rather than domestic) law. These are important ideas that will be returned to when we consider equity for Māori in a later section.

Of course, there have been no shortage of critics of the United Nations. One can point out that the United Nations originated from a war alliance against the axis during World War II and make a case that allies were looking to profit themselves at the expense of Germany, Italy, and Japan. There can be a great deal of controversy over whether a particular use of force is or is not in the 'common interest'. Still, this might be thought to be progress on a situation in which the 'common interest' is not thought to be at all relevant to whether or

not the use of force is justified. It is an advance on a 'might is right' mentality, in other words.

Another criticism is that while the above might sound like a civilised advancement the way in which it is applied in practice amounts to no difference. Still, this is an objection that can be heard and can be recorded to have been heard in a forum that is (at least nominally) responsive to reason whereas it has no chance of being heard or being recorded to have been heard in a forum that makes so such pretence.

The Charter of the United Nations outlines roles and scope for the Security Council, the Social and Economic Council, and the Trusteeship Council (concerned with the administration and ruling of occupied territories after World War II to help them transition back to the pursuit of economic and social development during a time of peace and security), and describes the International Court of Justice as the principle judicial organ of the United Nations, along with the role of the Secretariat. The Charter describes how the specialised agencies are supposed to work together to contribute towards the over-arching goal or aim of the United Nations.

Article 57:

> 1. The various specialized agencies, established by intergovernmental agreement and having wide international agreement and having wide international responsibilities, as defined in their basic instruments, in economic, social, cultural, educational, health, and related fields, shall be brought into relationship with the United Nations

3.1.2 The Social and Economic Development Council

The Social and Economic Council's purpose and scope is set out in Chapter IX Article 55.

> With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:
> a. higher standards of living, full employment, and conditions of economic and social progress and development;
> b. solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and
> c. universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion...

This sets an agenda as something for countries to set about doing, rather than setting about (for example) goals of expansionism and conquest and the destruction of some (by way of 'might is right') so that others may profit from taking their stuff. Of course, this is controversial since other countries might well point out that England got to be in the position that it did as a world power by colonial expansion (which it is now attempting to prohibit as a way forwards for other countries) and the USA got to be in the position that it did by diverting foreign resources towards itself in a way that exploited and entrenched poverty for those in other countries. By making deals with dictators that further strengthened their tyranny over their people, and so on. One can point out that the twin goals of Social and Economic development appear to be orthogonal, in tension, or perhaps even in direct opposition with

one another such that it is impossible to maximise one, without cost to the other. As such, the goal that the Social and Economic Development Council exists to pursue is an impossible one (Okun and Summers, 2015), . One can point out that the Millenium Development Goals paint a picture of a standard of living that is unsustainable for the billions of people existing on this earth and the many billions of people we project will exist in the very near future. This objection links back to the concern about who the primary beneficiary of the United Nations policies is supposed to be. One can maintain that full employment is unreasonable - even if we restrict it to adults with capacity - a functioning economy requires 5 per cent unemployment otherwise people won't do jobs that are required at current levels of remuneration. One can rightly point out that the United Nations and subsidiary organisations are fairly selective in which atrocities they decide to pursue as such. One can point out, again, that they seem more interested in preventing those they stand to profit the most from themselves.

In the face of these objections, perhaps we should simply abandon the ideal as a silly notion dreamed up by people very far removed from the realities of how civilisation is made and what is required for it's maintenance. Perhaps we should simply be free to pursue our own ideal. If this is the case, however, then I, for one, would take no consolation, whatsoever, for being right. I see adopting this position as a giving up, or a defeat. In short, we simply must work towards making it happen. There is no other way to be sustainable in this world.

3.1.3 The millennium development goals

In September 2000 189 countries signed the Millennium Declaration in which they committed to achieving a set of eight measurable goals by 2015.

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria, and other diseases
7. Ensure environmental sustainability
8. Develop global partnership for development

The Millennium Development Goals have been the subject of controversy. There has been concern that the Millennium Development Goals have been used as a political football to try and halt or slow the Social and Economic Development of nations such as India, Singapore, and China (for example) while doing nothing to temper the seemingly limitless demands and consumptions of the larger founding nations of the UN (primarily The United States, and England). On the other hand, we considered in the last chapter how these nations have been making genuine advances and developing on the world's stage. Let us consider the next turn for development.

3.1.4 The sustainable development goals

On 25 September 2015, the 193 countries of the UN General Assembly adopted the 2030 Development Agenda titled 'Transforming our world: the 2030 Agenda for Sustainable Development' (United Nations, 2015).

This new agenda has 92 paragraphs and paragraph 51 outlines the 17 Sustainable Development Goals (SDG) and the associated 169 targets which are integrated and indivisible (section 18.). Each target has between 1 and 3 indicators used to measure progress towards reaching the targets. In total, there are 304 indicators that will measure compliance. For example, Goal 3 is to ensure healthy lives and promote well-being for all at all ages. While the third goal explicitly mentions health there is overlap between the goals. For example, Goal 6 is clean water and sanitation. Ensure availability and sustainable management of water and sanitation for all.

> We are setting out together on the path towards sustainable development, devoting ourselves collectively to the pursuit of global development and of "win-win" co-operation which can bring huge gains to all countries and all parts of the world. We reaffirm that every state has, and shall freely exercise, full permanent sovereignty over all its wealth, natural resources and economic activity. We will implement the Agenda for the full benefit of all, for today's generation and for future generations. In doing so, we reaffirm our commitment to international law and emphasise that the Agenda is to be implemented in a manner that is consistent with the rights and obligations of States under international law (section 18).

The Sustainable Development Goals are:

1. End poverty in all its forms everywhere
2. End hunger, achieve food security and improved nutrition, and promote sustainable agriculture
3. Ensure healthy lives and promote well-being for all at all ages
4. Ensure inclusive and equitable quality education and promote life-long learning opportunities for all

5. Achieve gender equality and empower all women and girls

6. Ensure availability and sustainable management of water and sanitation for all

7. Ensure access to affordable, reliable, sustainable, and modern energy for all

8. Promote sustained, inclusive and sustainable economic growth, full and productive employment, and decent work for all

9. Build resilient infrastructure, promote inclusive and sustainable industrialization, and foster innovation

10. Reduce inequality within and among countries

11. Make cities and human settlements inclusive, safe, resilient and sustainable

12. Ensure sustainable consumption and production patterns

13. Take urgent action to combat climate change and its impacts

14. Conserve and sustainably use the oceans, seas, and marine resources for sustainable development

15. Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, halt and reverse land degradation, and halt biodiversity loss

16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable and inclusive institutions at all levels

17. Strengthen the means of implementation and revitalize the global partnership for sustainable development.

The Sustainable Development Goals are clearly a development or extension of the Millennium Development Goals insofar as what was formerly list of 8 things has now blossomed or swollen into a list of 17. It isn't the case that there is a straightforward mapping between Goals in the sense of sim-

ply breaking them down into components and articulating each part in more detail, however. Rather, sometimes less words have been used for greater, or more sweeping effect. For example, while Millennium Development Goal 2 focused on 'universal primary education' the Sustainable Development Goal 4 is to 'Ensure inclusive and equitable quality education and promote life-long learning opportunities for all'. While previously the policy appeared limited to only Primary educational providers it is now clear that the policy encompasses Secondary and Tertiary educational providers Goal 16 makes it very clear that tertiary education providers can no longer claim to be exempt. With respect to Health, while the Millennium Development Goals explicitly mentioned child mortality, maternal health, HIV AIDS and malaria as goals 4, 5, and 6; the Sustainable Development Goal 3 is to 'Ensure healthy lives and promote well-being for all at all ages'. While previously it appeared the UN was focused on the activities of agencies in developing, or third world nations (with high rates of infant mortality and communicable disease) it seems clear that the focus is now on the rather harder to measure or quantify issues of 'healthy lives' and 'well-being'.

3.1.5 The United Nations declaration on human rights

The United Nations Declaration on Human Rights grants people freedom without distinction on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability or other status (article 19). Article 23 states that:

> people who are vulnerable must be empowered. Those whose needs are reflected in the Agenda include all children, youth, persons with disabilities (of whom more than 80 per cent live in poverty), people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants. We resolve

to take further effective measures and actions, in conformity with international law, to remove obstacles and constraints

The notion of human rights has received a lot of criticism. One might say that the notion of rights is a lofty ideal that is unattainable in practice. For example, one view is that in order for a small minority to have any kind of quality of life that makes their lives worth living (from their own perspective) is for a majority to not have human rights, or, alternatively, if it makes sense to speak of those others having rights, then their rights are required to be persistently violated in order for the minority to retain what it is that they have. In order for this view to have any kind of credibility as a moral theory it requires a certain amount of buy-in. It might be considered fair for some people to take what they can get for as long as they can get because they can get it and not be affected by others being sore losers for not ending up with much in life - but only if it really were the case that those who don't end up with much in life are playing the same game that they are. Which is to say, that they would treat others similarly, if they had been lucky enough to have seen opportunity to have taken things and if they had have had the ability to step up to the plate when it came to that. The above game isn't typically regarded a particularly moral, or co-operative life strategy, however. Rather, it has been difficult for theorists to explain how it is that moral behaviour and co-operation could have persisted in the face of failure to co-operate.

3.2 The World Health Organisation

The World Health Organisation (WHO) is a specialised agency of the United Nations that is concerned with international public health. It was established on April 7, 1948 and signed by 63 countries. It has played a leading role in the eradication of smallpox and current priorities include communicable diseases

e.g., HIV/AIDS, malaria, and tuberculosis. The World Health Organisation Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July, 1946. There are 9 constitutional principles, though it is common to focus on the first two:

> 1. 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1946; WHO, 2006)'. 2. 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition (WHO, 2006)'.

At this point the sceptic might think that the World Health Organisation has defined health in such a way that it is an unattainably high, impossible ideal that does not and can not have any real, practical, import. As such, it doesn't make much sense for the World Health Organisation to regard health to be a fundamental human right. Or, alternatively, if this impossibly high ideal of health is a fundamental human right, then rights must be fairly vacuous sorts of empty things to have. This would be because the attainment or instantiation of states of affairs or circumstances satisfying them would seem to be simply not possible for many people, for much of the time.

Even if we weakened the first principle such that health was simply the 'absence of disease or infirmity' the sceptic might still think that it is an unattainably high, impossible ideal. For example, the sceptic might ask us to consider people who have had limbs amputated during their adult life. Despite our very best efforts, such limbs simply do not grow back and thus 'complete physical well-being' is unattainable or impossible for these people. The sceptic might also ask us to consider people who were born with congenital deficit or blindness, deafness, various forms of paralysis, or sensory dysfunction. The sceptic

might say that in these cases, too, 'complete physical well-being' is unattainable or impossible for those people Or consider the common cold for which there is no present cure. Full health seems to be an impossibly high ideal.

The sceptic might further wonder how many people can truly be said to be living in a state of 'complete physical, mental, and social well-being'. The sceptic will point out there is no shortage of wealthy people suffering from additions, a variety of eating disorders, a variety of body dysmorphisms, and so on. People seem somewhat attracted to hearing all about wealthy people and / or famous people and / or people who seem to have access to everything they could possibly need and then some who, despite all this, still do not seem to be happy people. There are no shortage of tales (presumably grounded in some kind of reality) about their unhappy and often unhealthy lives. The whole notion of well-being may seem elusive and it may seem unclear what sense we can make of, for example, these 'worried-well' or people who choose to use their access to resources needed to attain health to attain resources needed to attain their ill-health.

In the second clause the World Health Organisation talks about the highest 'attainable' standard of health. This may provide some resources for a reply to the sceptic. One might say that while not all people are able to achieve a state of complete well-being all people have the right to achieve the highest state of well-being that is attainable, by them. Later in the document Article 1 states that 'The Objective of the World Health Organization... shall be the attainment by all peoples of the highest possible level of health (WHO, 2006)'.

The idea here is that while people with certain kinds of disability might be thought to not be able to attain health in the sense that despite our very best efforts, limbs do not simply grow back and thus someone who is born with a

congenital absence of a limb might be thought not to be able to attain health in the World Health Organisations sense. There are two different responses we could make to this. Firstly, the loss of a limb might be a difference rather than a disability and as such there is nothing to prevent a person without a limb (without perfect mobility - whatever that means - perfect vision) being in perfect health. Secondly, while a person might have a particular health issue (loss of a limb, astigmatism, short sightedness) health might be more or less attainable insofar as treatments are attainable. Either because of technological limitations (limbs don't grow back) or financial limitations (not all prostheses grow on trees).

I don't know that what I have said in the last two paragraphs provides an entirely satisfactory response to the sceptic. Later we will see inequitable ill-heath as a condition arising from lack of resources needed to attain good health, however. Perhaps this contrast class helps the understanding. My focus is mostly on the latter.

The second principle introduces the idea of groups of people. Here, the relevant groups are explicitly enumerated as race, religion, political belief, economic or social condition. While every person has rights whether a person's right has been violated seems to be something that the World Health Organisation considers tied to their status as a member of a particular group.

> 3. The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.
> 4. The achievement of any State in the promotion and protection of health is of value to all.
> 5. Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is

a common danger.

The World Health Organisation links health to peace and security and explicitly mentions co-operation. Health isn't regarded to be a finite resource where people or organisations compete to have some at the expense of others needing to miss out. Some people attaining health doesn't make the world worse for others. Ill health poses dangers for us all (e.g., communicable disease).

Again, the sceptic might think that the World Health Organisation has an unrealistic view of health. The sceptic might think that the resources needed to attain health are finite such that it simply isn't the case that all people can attain the resources they need to attain health. The sceptic might think that the health of some is somehow intrinsically tied to the ill-health of others. For example, when students are learning they need to practice on people and when they are practicing, or learning, they are likely to make mistakes. Who should people who are learning practice on? Perhaps they should learn in our public health system. Who, then, are the high users of our public health system that get to bear the cost of their learning? Then, once they have learned are they able to function in our public system or are they forced into private healthcare if they wish to practice any of what they have learned, at all? In other words, perhaps, in order for some small minority of people to have competent, private, healthcare, there is required to be a larger majority who don't have access to competent, private, healthcare, but rather, are required to present to public systems in order for the health workforce to have plenty of patients such that it is possible for students to attain competence which is required for a small proportion of the people to have competent practitioners, at all. I will return to the issue of the distribution of costs.

6. Healthy development of the child of basic importance; the ability to live harmoniously in a changing total environment is essential

to such development.

7. The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

8. Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

9. Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

3.2.1 Disability

The WHO *Global disability action plan 2014-2021 better health for all people with disability*, (2015, pg., 1) states that:

> Disability is universal. Everybody is likely to experience disability directly or to have a family member who experiences difficulties in functioning at some point in his or her life, particularly when they grow older. Following the International Classification of Functioning, Disability and Health and its derivative version for children and youth, this action plan uses 'disability' as an umbrella term for impairments, activity limitations and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual (environmental and personal) factors. Disability is neither simply a biological nor a social phenomenon.

The World Health Organisation does not characterise disability as something that happens to 'other' people, rather, they focus on the universality of our

experience of it - as something that happens to our self, or will likely happen to our self, and also to the people around us. They mention both biological and social aspects of disability, but, notably, do not mention economic. They continue on to consider some of the factors associated with disability.

> Disability is a global public health issue because people with disability, throughout the life course, face widespread barriers in accessing health and related services, such as rehabilitation, and have worse health outcomes than people without disability. Some health conditions may also be a risk factor for other health problems, which are often poorly managed, such as a higher incidence of obesity in people with Down syndrome and higher prevalence of diabetes or bowel cancer in people with schizophrenia (World Health Organisation, 2015, pg., 1)

The go on to characterise associated human rights violations and, lastly, the association with poverty, lack of education, and lack of employment:

> Disability is also a human rights issue because adults, adolescents and children with disability experience stigmatization, discrimination and inequalities; they are subject to multiple violations of their rights including their dignity, for instance through acts of violence, abuse, prejudice and disrespect because of their disability, and they are denied autonomy. Disability is a development priority because of its higher prevalence in lower-income countries and because disability and poverty reinforce and perpetuate one another. Poverty increases the likelihood of impairments through malnutrition, poor health care, and dangerous living, working, and travelling conditions. Disability may lead to a lower standard of living and poverty through lack of access to education and employment, and through

> increased expenditure related to disability (World Health Organisation, 2015, pg., 1).

It is important to focus on the definition of disability that was contained within the first paragraph quotation that distinguishes having a health condition from having a disability. In order for there to be disability there needs to be 'impairments, activity limitations and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual (environmental and personal) factors'. In other words, not all people with health conditions are disabled by their conditions - and their societies response to their condition and / or their person. Disability is not an inevitable by-product or result of having a condition.

On the other hand, the World Health Organistion may be attempting not to *describe* disability, but to *predict* how it is that those who are diagnosed with disability will be treated.

3.2.2 Equity

The World Health Organisation (WHO, n.d) considers equity as a health system topic. There are three paragraphs in all that are often cited in a summarised or condensed version. These paragraphs are informationally dense, however, and I want to take the time to unpack them in a way that makes it easy to refer back to particular ideas / sections for analysis in the remainder of this thesis.

Paragraph one:

> Equity is the absence of avoidable or remediable differences[1] among groups of people, whether those groups are defined socially, eco-

> nomically, demographically, or geographically[2]. 'Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes[3]. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms[4].

1. In order for there to be an inequity there must be a difference between groups of people. That difference must be avoidable and remediable.
2. There doesn't seem to be restriction on the way groups are defined. This is supported later when there is a more specific statement on what is common to equity groups.
3.The differences (inequalities) that are relevant for health are differences with respect to: A) health determinants and / or, B) access to resources needed to improve or maintain health and / or, C) access to resources needed to improve and maintain health outcomes.
4. The existence of avoidable and remediable difference (difference that has not been successfully avoided or overcome by the group) in factors A and / or B and / or C entails an infringement on fairness and human rights norms.

Paragraph Two:

> Reducing health inequities is important because health is a fundamental human right[6] and its progressive realization will eliminate inequalities that result from differences in health status (such as disease or disability)[7] in the opportunity to enjoy life and pursue one's life plans.

6. The World Health Organisation considers health to be a fundamental human right. The WHO considers health to be to do with flourishing and attainment

of potential. It is aspirational, in other words, and not defined merely as the absence of suffering and / or disease.

7. There is an ambiguity as to whether disease and disability are regarded to be inequalities or inequities (where inequalities seem to be a certain kind of difference). This will be clarified in the next chapter.

The third paragraph:

> A characteristic common to groups that experience health inequities—such as poor or marginalized persons, racial and ethnic minorities, and women—is lack of political, social or economic power[8]. Thus, to be effective and sustainable, interventions that aim to redress inequities must typically go beyond remedying a particular health inequality and also help empower the group in question through systemic changes, such as law reform or changes in economic or social relationships[9].

8. Examples of minority groups include A) Poor people B) marginalized people C) racial and ethnic minorities D) women. The common characteristic is identified as lack of social, political, or economic power.

9. Effective and sustainable interventions involve empowering the group by altering the relationship dynamic and / or through systemic reform and / or through legal changes.

In this chapter I will start out focusing on the first paragraph. The identification of equity groups will be the topic of the next. Empowerment will be the topic of the last chapter of this thesis. I think a fair summary of the position, overall, is that:

Health inequity is when there are avoidable or remediable differences that a

population has failed to avoid or overcome. These differences are differences in health determinants and / or access to resources needed to improve or maintain health (or health outcomes). The presence of these differences entails an infringement on fairness / human rights. Or, to, perhaps make things a little clearer:

1. Differences between groups of people
2. Differences that are 'avoidable or remediable'
3. Differences in health determinants, or access to health-related resources
4. Differences that entail human rights violation.

On this analysis of the World Health Organisations position, the focus of paragraph one is really on the notion of difference. Only certain kinds of difference are relevant for inequities in health, however, and for a difference to be a candidate a number of things need to be true about the difference.

3.3 The New Zealand Ministry of Health

The Ministry of Health position statement on equity (2015) locates it within the following directory structure: Home > Our work > Populations > Māori health > He Korowai Oranga > The key threads > Equity.

Firstly, it is puzzling why it is that the Ministry locates the issue of equity within Māori Health since while equity is obviously a concern for Māori it is of concern for populations other than Māori. There may be resistence to my suggestion if equity is considered, in more concrete terms, to be a pot of money for people to fight over, however. I will return to this.

The Ministry of Health entry on equity is that:

> The World Health Organisation defines equity as the absence of avoidable or remediable differences among groups of people. The concept acknowledges that not only are differences in health status unfair and unjust, but they are the result of differential access to the resources necessary for people to lead healthy lives.

This is a fairly good restatement of the heart of the start of the World Health Organisations view. There may be some sort of ambiguity about whether the presence of inequality entails the presence of injustice, however. I will explain this immediately after introducing the case study The Ministry of Health provides - the example of immunisation rates for Māori.

> Progress in health equity. Some gains have been made towards health equity (for example, immunisation rates for Māori children have improved so much they are now equal to or better than non-Māori rates in much of the country.) However, more work needs to be done to achieve health equity for Māori and for all New Zealanders.

So, equity for Māori is defined as being a situation where immunisation rates for Māori are the same - or 'better' than rates for non-Māori, and in this context 'better' is equated with 'higher'. The idea of 'better' is important. Often, in the literature, there appears to be confusion or ambivalence when it comes to valence. Sometimes valence is included (e.g., in a causal chain like: Low levels of education > low levels of employment) whereas othertimes valence is mixed (e.g., in a causal chain like: Low levels of education > employment). One might think this innocuous enough - but this tendancy to mix things up highlights that the information provided can be used to effect very different

things. In response to this: We are agreed: We are trying to effect equity. But now we need to ask 'equity for who?' We are presented with two options: Equity for Māori, and equity for New Zealanders.

We have already considered three broadly different notions of equity. Firstly, the idea of fair distribution. Secondly, the idea of an amount overall (e.g., an increase in gross domestic product). Thirdly, the idea of inheritance - or keeping it in the family (e.g., equity trusts). People can agree they are trying to further the aims of equity while they are pursuing any of the above notions. This can be the case both for Māori and for non-Māori. Let us now consider how these notions of equity play out when it comes to immunisation.

Firstly, let us ask the question: Who is the primary beneficiary of higher rates of immunisation? The standard story is that the primary beneficiaries of immunisation are the free-riders who are not themselves immunised, but who benefit from a certain percentage of the people around them being immunised. This is because there are costs to having an immunisation. There is always some risk associated with any medical procedure. A needle stick provides a route of entry for pathogens which might go on to infect or cause medical problems for the recipient. The foreign material present in the immunisation might cause an immune reaction that becomes excessive or extreme or targets healthy tissue of the recipients body. The likelihood that the individual who is the recipient of the vaccine will actually catch the disease they are being immunised against (if they were not to be immunised) is typically very low. The harms of the disease the recipient is being immunised against are also typically very low. Measles doesn't cause too many problems for healthy, robust individuals with good immune systems. Measles can be deadly in those who are immuno-compromised. It typically isn't the case that immuno-compromised individuals are recipients of vaccines, however. Again, the standard story is that the primary beneficiaries of vaccination are the individuals who are not themselves immunised and who are benefiting from herd

immunity. The standards story is also that those who benefit the most are those who are immuno-compromised who are likely to suffer greatly if they become infected. Immuno-compromisation can be due to many things. Particularly, due to immuno-suppressant therapy to assist with cancer treatment, or in individual's who are HIV positive (for example) but are functioning okay due to their access to anti-virals. Māori are under-represented in these populations, however, so it seems very hard indeed to understand the claim that higher rates of immunisation in Māori are something that primarily benefits Māori even though we can understand that they have been the target for intervention (higher rates of immunisation for Māori).

Smallpox only required around 50 per cent of the people to be immunised to result in sufficient herd immunity to protect the population and that is why smallpox vaccination programs were so effective. It has been estimated that immunisation rates sufficient to provide herd immunity to measles (given current sorts of standards on housing and overcrowded living conditions) is around 94-97 per cent, however (Hawe, 1994, in Baum, 2015, pg., 492). This is what has made it so hard to eradicate measles (in current housing conditions) with vaccination programs.

The standard story on lower rates of immunisation for Māori historically is typically told as one of lack of access to immunisations, however. The idea is that historically Māori didn't have access to the doctors or the allied health professionals who, in turn, had access to the immunisations that would help their people. The primary beneficiary, here, is typically cast as being not the broader non-Māori (eg., tourist) society, but rather Māori, themselves, in the name of equity. It is supposedly because of this historic lack of access to immunisations that makes it the case that Māori having higher rates of immunisation now would be a situation that is *better - for Māori*

We need to distinguish as being better for Māori, or *better for society overall* (at the disproportionate expense of Māori). Immunisation strikes me as being a

case that is better for the world overall when rates are 95 per cent - but finding that a group of people have disproportinately higher rates of immunisation is finding a world where that group of people are bearing a disproportionate amount of the burden or cost that goes in towards that greater good. It is *not* a case where the primary beneficiary is the named equity group.

I am not advocating that Māori not have their children immunised (in the name of equity) but I am just trying to raise the idea that it is not clear that Māori are the primary beneficiaries of having higher rates of immunisation. When the issue is cast (as it typically is) as one of *access* to medical treatment - I still have trouble understanding how Māori are supposed to be the primary beneficiaries. The issue is not one of immunising more Māori kids. The issue (especially with regards to empowerment) is one of more Māori being *offered* immunisations. This is the crucial last part of the World Health Organisation view that our Ministry of Health leaves out - the idea of *empowering* equity groups. For example, *empowering* Māori to make informed decisions about whether they want to participate in immunisation programs, or not. Statistics aren't being kept on how many people have made an informed consent decision about whether their child will be immunised or not, however. Rather, the statistic that is regarded to be relevant (in the name of equity) is one of actual rates of immunisation. The measure does not seem to be one of empowerment, in other words, the measurement appears to be one of compliance. And not so much for their own good, but more at their expense.

Baum (2015, pg., 492) states that with respect to Australian Populations: 'The AIHW (2012) reported that here are only very small differences in rates of immunisation between advantaged and disadvantaged and Indigenous and non-Indigenous Australians'. Whether there are good reasons to believe the AIHW statistics, or not, Baum thought it was worth stating this. It seems especially worth trying to make this claim in a context whereby, for example

'From 2012 parents had to have their child vaccinated in order to receive family benefits payments (Baum, 2015, pg., 492). We are not told that from 2012 parents had to have their child vaccinated in order to attend x or y wealthy private school, on the other hand. We might well worry whether the poor and the Indigenous are being targeted to bear a disproportionate amount of the burden of the production of herd immunity. Especially if they are (for example) never likely to be the recipients of immuno-suppressant therapy (e.g., following cancer treatment, transplant, HIV medications) which would allow them to survive in an immunologically compromised state, and the like, where these people (and not the healthy wealthy) were (at least nominally) supposed to be the primary beneficiaries.

I don't understand how anybody can think that Māori are the primary beneficiaries of a policy whereby rates of Māori being immunised at higher rates than non-Māori is for the primary benefit of Māori populations. The Ministry of Health website seems to be intentionally asking us to consider / reconsider equity and try and unpack it in some way such that it makes sense.

To be clear; I am not advocating that people not be immunised. A world in which we have herd immunity is a better world than a world in which we don't. But (and this is crucial) a world in which *no group disproportionately bears the cost of the production of that world* - is best. Equitable equity, in other words. We need to work towards the development and protection of an infrastructure such that 95 per cent of people in the world will provide informed consent to contribute to the cost of bringing that world in to being secure in the knowledge that they and their people are not being asked (or conned) into shouldering a disproportionate amount of the cost of it's production.

Medicine has historically a very bad track record when it comes to intentionally

infecting people with various things (or of knowing they have been infected and allowing / persuading them to believe otherwise) when there appears to be the possibility of tracking those subjects over time and seeing the effects of what was done to them. The Cartwright Inquiry shows that New Zealand is no stranger to observational studies that are of dubious benefits to those who are the subject of observation. When clinics are targeted towards certain populations rather than being mixed one would be wise to be cautious about different batches (for example) being distributed to different clinics in order to further entrench inequity for some peoples - in the name of a supposed increase in equity overall. It would be disingenous to suggest otherwise. We need to get more serious about equitable distribution of equity or we are likely to end up in the position where there is a crisis of faith in the people, and possible civil war. We have seen already that inequality has been considered the biggest threat to peace and security and economic development of nations.

The United Nations prefaces itself on the notion of peace and security and we need to understand trade as being mutually beneficial rather than as something intrinsically or necessarily exploitative.

3.4 District health boards and primary health targets

New Zealand has 20 district health boards, with 11 members on each board (for a total of 220 board members). In the document *Building a Healthy New Zealand: Becoming a DHB board member* the Ministry of Health (2013) outlines something of the purpose and scope of the District Health Boards of New Zealand in order to inform prospective applicants. The boards have a:

> combined budget of over $11 billion, representing 75 per cent of the government's total health budget... Their basic function is to

> plan, manage, provide and purchase health services for their communities so that New Zealanders have access to quality services when and where they need them. DHBs own and run our public hospitals, but their reach extends even further. GP visits, disability services, pharmacy prescriptions, laboratory tests and mental health and addiction services all come under the DHBs' jurisdiction. DHBs also fund community and residential care and deliver health promotion programmes to improve the overall wellbeing of the communities they serve.

They go on to describe how the performance of DHBs is assessed:

> DHBs are required to deliver on specific health targets set each year by the government. The current health targets are: shorter stays in emergency departments; shorter waits for cancer treatment; improved access to elective surgery; increased immunisation; better help for smokers to quit; more heart and diabetes checks.

The Conversation (2017) described New Zealand's health system as part of a global series about health systems. In article entitled: *New Zealand's health service performs well, but inequities remain high.* The role of the District Health Boards is to:

> [D]irectly deliver hospital and hospital-led community services (such as district nursing services), and contract for primary health care services through 36 Primary Health Organisations (PHOs). These in turn contract with general practices or health care homes to deliver primary health care. DHBs also hold contracts with a range of other primary health care providers, such as pharmacists and laboratories, and with many private for-profit and private not-for-profit

> organisations delivering community care (for example, services for mental health and home-based care for older people).

So the flow of money from the Government to the District Health Boards who distribute money to maintain and develop public infrastructure and services and also to contract out to private providers. They describe the public health system focus:

> In recent years, the New Zealand government has focused on a range of performance targets that it monitors. For the health-related "better public services" targets, New Zealand has seen increases in the rate of child immunisations, but not all DHBs and PHOs are hitting the target of 95% of eight-month-old babies being fully immunised. Other trends show that most DHBs are meeting targets for increasing the number of elective operations and for ensuring that 95% of people are seen in an emergency department within six hours. Performance against the target for smokers to be offered assistance is also good, though a bit variable across DHBs and PHOs. The targets for raising healthy kids (where 95% of obese children identified in the Before School Check programme should be offered a clinical assessment and family-based interventions) and for cancer treatment (to begin within 62 days for 85% of people require more work in many DHBs... The strain on services is appearing in media reports, highlighting poor performance in mental health (including high rates of suicide, especially amongst young people and Māori) (The Conversation, 2017).

With respect to our funding model:

> New Zealand generally spends less per capita on health care than other countries... Increasing concerns are being expressed over

> problems people have in getting to maternity, oral health, cancer and elective services. This is likely to be leading New Zealanders to purchase private health insurance in increasing numbers, which raises concerns over ensuring there is equity of access within the health service, as those on higher incomes are more likely to buy insurance (The Conversation, 2017).

In 2018, and in every year, the District Health Boards are required to provide statistics on certain health targets that are set by the Ministry of Health as are the Primary Health Organisations. The service is not trying to be responsive to the people, it is trying to get the people to comply with the targets the Ministry of Health has set. Or, to encourage people to purchase private health insurance. We have seen previously that many people in New Zealand don't earn enough to be able to purchase private health insurance or to make co-payments on health care. Pre-existing conditions are typically not covered by health insurance, so there is no health insurance to cover people who have been diagnosed with disability early on.

With respect to the distinction between health and health outcomes or health and health targets we need to consider that health is not measurable by quantitative analysis and this is why it is tempting to focus on measuring and reporting proxy measures (objective, quantitative health outcomes) or focus on pursuing proxy goals (health targets). Just because health is not amenable to quantitative analysis does not mean it is of no value, however. Rather, it means it is of immersurable value. It is important to remember that not everything worth measuring can be measured, and a great many things that are highly measurable really are not worth measuring, at all. The World Health Organisation appeals to what is apparent, or visible. This takes some commonsense and a willingness to try and apprehend the notion of health rather than argue for the sake of argument, or be destructive. People can typically tell whether a plant is healthy (flourishing, thriving, doing okay) or whether it

looks sickly. We can typically tell whether an animal is healthy (flourishing, thriving, doing okay) or whether it looks distressed / agitated / sickly. We can typically tell whether people are doing okay, or whether they are distress and unhappy and sickly in demeanour. These things are hard to quantify, however. Much of the food industry is attempting to maximise profits by having people select fruit and vegetables and meat and dairy that is cheap to produce at great volume rather than selecting produce that appears healthy (e.g., by treating 'fresh' produce with preservatives and waxes and the like to make it appear shiny / healthy without much concern on the healthfulness of eating waxes). Artificial selection and modification have intentionally obscured things as fruits are selectively bred for higher sugar contents and lower levels of phytochemicals and antioxidants because the former just taste tastier and will tend to be consumed at higher volume (e.g., sweet apples vs tart apples). It is important to remember that health outcomes have been introduced as a proxy measure for health, however, and not to confuse the health outcomes with the overall goal. And not, even more in particular, to end up pursuing some proxy measure at the overall expense or detriment to the elusvie notion of health that was the initail motivation or driver behind the whole thing.

For example, let us consider '95% of people will not remain in the Emergency Department for more than 6 hours' as a health outcome. If this health outcome is the goal then a District Health Board can report whether the goal has been attained or not and also report how far off the attainment of the goal they were if they were unable to achieve 100%. If this health outcome is a proxy for health, however, then we might consider that there are ways of achieving the proxy that are likely to result in an increase in health and there are ways of achieving the proxy that are unlikely to result in an increase in health. For example, consider the following ways of achieving the proxy, while likely not achieving an increase in health:

- Position security guards outside the front of the ER and turn away the majority of people who show up.
- Have receptionists turn away people who show up – telling them they should follow up with their GP the next day.
- Have St Johns or the Wellington Free Ambulance service take the majority of people to after hours GP clinics, rather than to the Emergency Department of the hospital. - Have nurses or other staff tell people who have been waiting for more than 5 hours to go home and follow up with their GP the next day.
- Have people transferred into a differnet section of the hospital that is 'strictly speaking' not considered part of the Emergency Department once they have been waiting for more than 5 hours.

While these will individually or together combine to produce the desired health outcome they seem to miss the point when it comes to the health outcome only being of value to us because, or in virtue of, of it's presumed relation to health. It would be worth considering how or why this outcome is considered to have relation to health. This needs to be made explicit before we can see whether we should care about the proxy goal.

In this chapter I have considered the UN and the UN view of health and how we get from there to the targets or goals of the Ministry of Health and the District Health Boards. This notion of health will be something I return to in the final chapter. The theme of the Ministry of Health and District Health board targets will be picked up on in the next chapter when we consider statistical parameters, surveillance of a vast range of information (in the name of health equity) and capitation funding.

Chapter 4

Equity groups and statistical parameters

4.1 Kinds of kinds

In the philosophy literature there is a standard distinction between mathematical abstracta, natural kinds, social kinds, and nominal kinds. I will briefly introduce them here, in order to raise some issues around natural kinds. I will then briefly introduce the notion of statistical parameters (e.g., sex at birth, race, NZ-deprivation score) that are used to group or type people for purposes of prediction. We will then be in the position to consider some of the 'equity groups' (parameters that have been associated with bearing the negative end of the inequality). Both in the present, and into the projected future.

The idea, roughly, is that mathematical abstracta (e.g., circles, triangles, equilateral triangles) have essences or natures that shapes must have in order to count as members of the kind. This essence or nature is something that can be determined a-priori. We can define up mathematical abstracta. For example (the standard story goes) 'an equilateral triangle is a three sided closed plane

figure with sides of equal length'. These conditions are essential for something to count as an equilateral triangle: These conditions are individually necessary and jointly sufficient for something to count as an equilateral triangle. All and only those things that meet those conditions are equilateral triangles.

There is some controversy over whether mathematical abstracta exist independently of our defining them up (e.g., in an abstract or Platonic realm), or whether they are created as abstracta by way of our defining them up, as some kind of performative utterance - but the basic idea is that the essence or nature of these things is a-priori. Hunting about in the natural world will not help one get clearer on the nature of triangles. There aren't any actual triangles in the natural world, anyway, only dim (and imperfect) copies of triangles - or, depending on one's theory of abstracta, imperfect instantiations.

Natural kinds, on the other hand, are thought to have essences whose nature is to be a-posteriori discovered by the natural (physical and life) sciences. Paradigmatic instances of natural kinds include substances or stuffs - such as water and gold, and living things - such as lions and elm trees. An example of the success of science was the discovery by the physical chemists that water was H_2O. The idea is that a-priori (on a narrow content view, anyway) water could have turned out (it was conceivable that it turn out) to have been any number of things e.g., H_2O_2 or H_2O_3. A-posteriori, a process of scientific investigation and discovery resulted in our coming to understand it's true nature, however. All and only pure samples of water have chemical composition H_2O and that substance in a liquid phase (the standard story goes) is water.

One may well have hoped that microbiology / genetics would do for biological creatures what physical chemistry had done for substance or stuff. The standard story, however, is one in which genetics had trouble distinguishing

between a person and a fruit fly - because of the high degree of relatedness of life and the mind-bogglingly large amount of DNA contained within chromosomes comprising the genome of living organisms (see, for example, Shih, Hodge, and Andrade-Navarro, 2015). It might be the case that we will end up with something more like individually necessary and jointly sufficient conditions for species membership out of genetics - eventually. Currently there are limitations involved with the cost of sequencing (between organisms, and also assessment of variation between cells within the same organism). Currently there are technical limitations involved with processing the genetic data. More sophisticated software analysis might be able to recover some of the apparent certainty we had with chemistry analysis, in other words. Putting this to one side, the standard line in philosophy has become one where rather than looking to microbiology and genetics for fixing biological species membership, we should turn to evolutionary biology and the notion of ancestral relations.

The idea that a single species can evolve into two distinct species over millennia has been interpreted by some as an undermining of essentialism about biological kinds. On the other hand, while the periodic table of elements appears non-gradualist it is possible to transition one kind of substance into another kind of substance (at great cost - e.g., via use of a proton gun). Also, there may well be an evolutionary account of the consolidation of matter after the big bang. So, perhaps the idea of transition from one species into two distinct species need not undermine essentialism about biological kinds in biology any more than taking gradualism seriously in chemistry would undermine essentialism about the substances listed in the periodic table of elements. Still, atomic number is necessary and sufficient for determining which element a sample is a sample of but there have been no genetic markers that seemed able to play that role for biology. Still, there is much that we don't yet know about genetics. The idea is still one of our deferring to the authority of the natural sciences when it comes to where to look for the nature of biological

species or kind membership.

Social kinds have been raised as something of a contrast class to biological kinds. Sometimes the issue is cast as one of nature (biology) vs nurture (culture). The kinds (or statistical parameters) that we will go on to consider might be regarded more as cultural kinds than as biological kinds. There has been quite a lot that has been written on social kinds e.g., psychological categories like emotions and institutional kinds like banks and universities. People have argued that gender and race are not biological inevitabilities - they are social constructions. This is to say that any predictive power that we gain from knowledge of kind membership is due to contingent facts about our social institutions. I have much sympathy with this line. It is because it is possible to alter our social practice and create more equitable future that our decision to not alter our social practice and create more inequitable future is unjust.

Nominal kinds, on the other hand, are kinds 'in name only'. The idea, here, is that we can define an arbitrary set any old way we like. I can define up a mathematical object that I call 'blub' and stipulate that members of 'blub' are: the letter 'a', the number '2', my left sneaker, and the moon. Of course there isn't much of anything else that I can say about blub. It has 4 members and the members don't seem to have anything in common other than being members of the category or kind blub. While one might think that nominal kinds don't have essences, one might reply that they share the essence of being members of the kind. This essence seems to be a fairly useless sort of a feature, however. More importantly than lacking an essence, the standard story goes, the problem with nominal kinds is that they are not projectable. If we know that something is a member of kind blub we can't predict anything more about it.

Disjunctive kinds such as duck-rabbit - where something is a duck-rabbit if and only if it is either a duck or it is a rabbit are projectable, however. A disjunction of duck-rabbit projectable features is predicable on the basis of knowledge that something is a duck-rabbit. Gruesome categories seem to me to pose a very genuine problem. I don't have a solution to the problem of grue. I won't have anything more to say about these sorts of problems of kind membership, here, however. My focus is more on what we have been inclined to regard as 'equity groups'. Instead of regarding them to be 'equity groups' I want to instead regard them to be statistical parameters. The idea of projectability is now one of placing bets on how things will likely turn out. Betting on duck-rabbit is not likely to get me as rich as I could get betting on ducks and rabbits. I mean to say that knowledge that something is a duck, rather than a rabbit should (fairly intuitively) provide additional information that will enable me to get richer when predicting likely futures for particulars with knowledge of those parameters / knowledge of membership in those kinds.

4.2 Case studies in kinds of people

People have long been interested in this notion that there might turn out to be importantly different kinds of people. For example, people might come in the kinds male and female where it is natural that males do the work to earn the money and females do the childcaring and homemaking. People might come in the kinds black and white and yellow with innate biological differences including increasing amounts of innate mathematical aptitude. People might come in biologically constrained castes or classes such as the ruling class, the working class, and the petty criminals, and vagrants. People have long seemed rather obsessed with distinguishing between 'me and mine' vs 'the other'. The 'in-group' and the 'out-group'. There has been much work devoted to whether humans do come (biologically) in different kinds, or whether differences that

we observe are more superficial than real (e.g., in the case of skin colour) or as contingent factors of our socialisation, or as induced by institutional / environmental factors (e.g., mental retardation arising from unequal exposures to chemicals / toxins) rather than as a matter of biological inevitability quite aside from our social practices. This seems important because if differences are not biologically inevitable, if it turns out that they are 'avoidable' by way of legislation or alteration to our social practices - then the induction and / or maintenance of inequalities might be thought to be inequitable - in the sense of being unjust.

We have seen already that there was suggestion that we focus on who the primary beneficiaries are. Despite this, the identification of 'equity' groups has in practice not involved our identification of who the primary beneficiaries are (e.g., a certain sub-group of white ancestrally northern European males with prime urban real estate holdings - and their families) but rather an identification of those who are the victim of inequities.

In New Zealand:

> health inequalities have been associated with an array of social factors, the most consistently interrogated being class or socio-economic status, gender, ethnicity, and geographical location... How these social factors impact on health depends on how they interact with each other, as well as the particular historical moment and its specific alignment of politics, economics, culture and social practices (Matheson and Dew, 2008, pg.,9)

Let us now briefly consider the different equity groups that have been proposed in the New Zealand context. Note that this involves our identifying not who

profits from the way that things are, but rather identification of the current victims of inequality.

4.2.1 Biological sex, gender, sexual orientation, marital status

While it was traditional to think that people came in one of two kinds: Male and female the reality is more of a genetic, morphological, and behavioural continuum. Genetically, more variants are possible for humans than XX (female) and XY (male). Morphologically, the development of the foetus is typically described as one in which female is the developmental default. The 'sex determining region' on the Y chromosome (the SRY gene) initiates the pathway for testes to develop. In the absence of SRY, the gonads develop into a female. If a live birth produces an infant with a non-functioning penis common practice has been to remove male gonads for a closer approximation to female morphology. Largely for convenience because so much of our society is structured around gender (e.g., public bathrooms and changeroom facilities, constant requirements to state gender on forms and birth certificate as verification of sex).

Gender identity is something that can come apart from biological sex at birth. There has been controversy over whether appropriate treatment for Gender Identity Disorder (if we view it as a disorder) is sex reassignment surgery / treatments to alter morphology, or whether it is psychiatric or psychological treatment to alter the mental acceptance of the morphology. Western society has not typically been very accepting of cross-dressing or trans-gender people perhaps because it has not typically been very accepting of people with non-normal physical morphology. Other cultures have been different, however, with eunuch and third gender accepted as more culturally normal ways of being.

Homosexuality used to be considered a disorder but is no longer. It was also

criminalised but largely is not anymore. Still, many people claim they feel targeted for discrimination on the basis of their sexual preference. Similarly, there has traditionally been pressure on people to marry - perhaps to indicate in some way that they weren't homosexual. There has been a notion that an upstanding person should take a wife and have children and this notion that there must be something wrong with the person if they do not choose these things for them self. Most of the discrimination against homosexuality, traditionally, was against men.

With respect to gender we have the majority - minority group of women. Women comprise over half the population yet traditionally women were largely confined to roles that were thought to be suitable for them because of their biological inferiority when compared to the male ideal. Of course when there was no suitable first born male, or no suitable male, the lot of females (of certain classes, anyway) was much better. Women were expected to step aside and defer when there was a male in the vicinity, however. Women were typically characterised as being the 'weaker' sex. Not capable of physical labour or sport as men were. Prone to injuries because of their deformed anatomy. The female body was traditionally characterised as a weaker and intrinsically inferior version of the male body. One that was deformed for the sole purpose of childbearing. There is still concern that while representation of women is increasing (e.g., in Medical School) there is more expectation that they will defer to males - either by choosing to marry a doctor on graduation and / or by selecting a speciality in which there is less male competition.

Similarly, female sensibilities - diplomacy, co-operativity - were thought to be the products of a mind that was inferior to men. A mind that was deformed, again, for the purpose of child-raising. The cyclical nature of women's natural hormonal cycle was thought to be appropriately characterised as a natural imbalance or the result of an unreasonable unpredictability. There

were arguments around not allowing women a university education - not least because allowing women to study at university was thought to be something that would be likely to distract the men from their studies. Mostly, those who were the primary beneficiaries of the subjugation of women were not responsive to reason when it came to not only allowing women to pursue things that were traditionally reserved as the preserve of a few elite men, or to allow women reproductive control over their own bodies instead of having their fate determined by men.

We hear that much progress has been made for women, in developed nations, in recent years. For example, Rashbrooke relates how:

> In the workplace, the gap between women's and men's earnings has narrowed since the 1972 Equal Pay Act was passed, but progress has slowed in recent years. The gap in average hourly earnings is now about 13 per cent, and is much wider for weekly or annual earnings. Women are over-represented in part-time work and do less overtime (Rashbrooke, 2013, pg.5)

We also hear how:

> 'Another factor in the pay gap is the lower proportion of women promoted to senior positions within almost every occupation, including Parliament and company boards. Women are also concentrated in particular occupations and sectors, many of them low-paid and, arguably, undervalued (Rashbrooke, 2013, pg 5)'

We can consider that things may have improved for women in more recent years. A recent increase in wages for those on low levels of wages in the 'traditionally female' occupations of aged care might be viewed as a victory for women insofar as it improves the status of a profession that was traditionally

a female preserve. On the other hand, we have already considered how pay increases for chief executives (traditionally a male preserve) were around 20-25 per cent, per year. In other words, it does not seem to be the case that pay increases (across all fields) primarily benefited women. On the other hand:

> A girl born today can expect to live for more than 80 years if she is born in some countries - but less than 45 years if she is born in others (Commission on Social Determinants of Health, 2008, preamble).

It has been considered that females are more costly to have and that when times are tough there tends to be more males relative to females being born. During one child policies there were a decrease in the proportion of female foetuses that were carried to term. This shows us that discrimination against females is not a thing of the past. The World Health Organisation tries to make governments accountable for these kinds of statistics (the birth rates of males compared to females) partly because problems would arise for us all if females were eradicated, for example. The lot of women in life where there is no birth control and where there is a high prevalence of crime against women (i.e., rape) is a world that is very harsh on women, indeed. It is a lot where biological difference (the fact that women bear children and not men and women lactate and not men) has a significant impact, indeed, on the sort of future a woman can have. It is important not to undervalue the role of access to birth control for women when it comes to the empowerment of women to futures that are not inexorably tied to inequalities of biology.

One criticism of the millennium development goals was that the high standard of living enjoyed by some could not be sustained across an exponentially growing population forever. One response to this concern of exponential population growth has been a focus in the sustainable development goals on empowering

women by way of providing them with greater access to birth control. While it is not the case that all women would choose not to have children when they are not likely to be able to raise them with access to certain resources, it is the very likely the case that significantly less women would choose to have as many children into poverty and deprivation when they have the means to prevent this. Because of the inequalities in morphology (with females bearing the foetus for 9 months and with female lactation) the female body is required to bear most of the costs (compared to the male body) of child-birth and the initial phase of child-raising. Access to medical technologies and infrastructures (e.g., birth control, breast-milk co-ops, infant milk formula) have loosened the grip of biology for determining the fate of the female body.

There used to be a lot of research devoted to trying to catalogue the 'natural' differences between males and females. For example, that boys engage more in roughhouse play with each other whereas girls engage more in social grooming. That boys would naturally bang on pots like a drum set whereas girls would play-cook with them. These studies failed to distinguish whether the differences (if statistically significant differences were found) were due to different socialisation or whether they were biological, however. Perhaps it was because girls are babbled to and groomed more but boys are jostled and rough-housed more that the behaviour grows to conform to these norms more often than not. There was also research into intellectual differences such as boys being more mathematical and spatially inclined whereas girls were more verbal.

4.2.2 Racial ancestry, ethnicity, skin colour

Indigenous people are commonly regarded as equity groups in countries with a history of colonisation (e.g., Australian Aboriginal, New Zealand Māori, Amer-

ican and Canadian Native Indians). Certain other minority groups are also regarded as equity groups (e.g., Pacific Islanders in New Zealand, Torres Strait Islanders in Australia, Hispanic and African-Americans in the USA).

There used to be much work devoted to investigating the genetic basis of race, particularly. It is common, now, for people to acknowledge that the concept of race is more of a social construction than a biological one. Most people are of mixed ancestry, for example. There aren't any full blooded Māori without some European Ancestry in their recent few generations. The search for genetic markers had by all and only people with a Māori ancestor in the last, say, 12 generations, has not been forthcoming.

The concept of ethnicity has something to do with how people identify as being. People are often asked to state which ethnic groups they identify as being a member of on forms, for example. There has been much controversy over whether 'New Zealander' is an ethnicity or whether people claiming to be 'New Zealanders' were racist insofar as they were denying differences between Māori and non-Māori for the primary benefit of non-Māori. People stating 'New Zealander' have been recoded as non-Māori in New Zealand in our recent history with this interpretation of their behaviour as the primary motivator (Cormack and Robson, 2010).

Skin colour, or physical appearance is something that people can't really change about themselves - though of course there is an industry in people trying to bleach their skin whiter in parts of Asia where lighter colouration is perceived as more desirable. While some people with claim to ancestral indigeneity or ancestral equity group status would not be classified or appreciated as such on the basis of physical appearance other people are fairly readily identified or classified by others as such. In Australia, for example, part of the

stolen generation was about identifying youths who appeared non-Aboriginal and attempting to raise them as non-Aboriginal orphans in institutions.

This element of choice is an interesting one. The idea that some (but not all) people are able to choose what they say with respect to their ancestry and choose what they say (and how they behave) with respect to their ethnicity. People can't really choose their skin colour, but people can choose to adopt or refrain from elements of cultural dress.

The primary reason why we are supposed to regard indigenous people as equity groups is because colonisation posed a very real threat to these peoples. Resources were taken from them such that they were unable to continue on with their way of life. Rather than being treated as persons and being traded with fairly in a way that was of mutual benefit colonisers were the primary beneficiaries of trade (or war) with indigenous people. It is because of this history of inequality of access to resources needed to attain health that we are supposed to be particularly mindful of allowing indigenous people a way of life, now. Genocide is regarded as a war crime but it is often less clear whether there is genocidal intent in situations where a certain race or cultural group of people is clearly being exploited to the benefit of some other group of people. For example, It was considered an attempt at genocide that the Nazi's were intending to exterminate the Jewish people and the Gypsies. It was not considered genocide that the English failed to intervene during the Irish Famine (e.g., by stopping food exports from Ireland or by legislating to return land to the Irish people instead of requiring them to pay rent to English Gentry by way of property managers).

The UN is interested in statistics around birth rate and death rate and age of mortality partly to keep an eye on whether a group of people appear to be bearing the brunt of discrimination / persecution. This is why the New Zealand

Government is supposed to keep an eye on Māori health statistics. If the inequality becomes too great between Māori and non-Māori in New Zealand then the Government might be accused of racial discrimination resulting in genocide or an attempt at genocide towards the Māori people. The Government has a duty to eliminate inequalities between Māori and non-Māori.

There has been much made of trying to separate out the effects of being Māori from the effects of being poor. The idea is that perhaps the worse outcomes for Māori are not race based inequalities if it turns out that being Māori has been confounded with poverty. In other words, if it appears that Māori have worse health than non-Māori we need to control for poverty because more Māori are poor and we have already considered the socio-economic gradient to health.

4.2.3 Geographical mesh block

Inequality in geography has typically been about differences in life chances between people of high vs low income countries. For example, the difference in mortality for infants born in South Africa compared to Norway or the United States of America. Sometimes differences in geography has been focused on differences in geographical location within a country. For example, differences in life chances for people in the urban city of Hong Kong compared to people living in rural China. Or, differences in life chances for people living in urban cities such as Sydney or Melbourne compared to people living in the Australian outback.

More recently we have this notion of a mesh block unit and the 'level of deprivation' we can associate with various mesh block units which contain around 90 people. Mesh block units are the smallest geogrophical unit or grid of space in which people reside that has been defined by Statistics New Zealand. We can consider various statistics about mesh block units such as the average age

of inhabitants, the number of inhabitants, the average income of inhabitants, the average level of educational attainment. We can also consider features of mesh block units such as proximity to various social services and accessibility of various aspects of infrastructure to do with, for example, water source, soil type, air pollutants and so on.

4.2.4 Poverty and the NZDep score

A measure of poverty in New Zealand is the NZDep Index of socioeconomic deprivation for small areas. It is an area-based measure combining variables from census data. The areas are built from one or more contiguous meshblocks. These blocks are given scores from 1-10 where 10 indicates the most deprived 10 per cent of small areas with respect to each of the measured indicators of deprivation. While it has been noted that the level of deprivation experienced by individual's living in a mesh block may vary (e.g., the bulk of the resources might go to the first born male) it has been a common practice to take NZDep score as an indicator of an individual's level of poverty (e.g., to assess the socioeconomic status of people in Health Science Professional Degree Programs (Crampton, Weaver, and Howard, 2012; 2018).

There has been fairly surprising reluctance to consider poverty to be an equity group. Typically, the idea is that Māori, or people with disability, or refugees, for example, are equity groups because more of them experience poverty. Poverty itself is often not considered an equity group. Poverty is sometimes regarded as an equity group and other times not. Prevailing theory in economics does not consider poverty to be an equity group and does not consider that inequality (ie., of wealth) is tied up with inequity - (that extreme differences in resource distribution is inequitable). Instead, poverty

is considered inevitable because life is about taking what you can for as long as you can because you can and there will be winners and there will be losers and there is never enough to go around and that is the game of life. Equity, rather, is tied up in other notions such as gender or race. Typically with the idea that there will be a decrease in overall equity (e.g., gross domestic product) if we keep subsidising people for their gender or race. The socio-economic gradient (that those lower in socioeconomic status have less access to health and health resources) isn't typically thought to be a problem from the prevailing perspective of economics. Because NZDep score is a relative measure of poverty (where one is located in 10 per cent brackets) it is focused on position in a social hierarchy rather than being independent of where others in society are positioned. It is thought to be inevitable that some will have and others will not. The socioeconomic gradient is thought to be a fact of life rather than an injustice.

4.2.5 Disability

Prevailing theories of economics don't consider disability an equity group, either, because disability is something along the lines of a poverty in health. People with disability have worse health outcomes is something that is thought to be conceptual, rather than contingent. Economic theories focus on DALYs as the inevitable cost of disability and tragedy of years of healthy life lost to disability rather than on how the tragedy is largely the result of how we treat people with disability. Consider the following description of disadvantage for deaf people with respect to their access to education:

> Most sign language users have been deaf since infancy, and the resulting disruption to language acquisition typically has far-reaching developmental and educational impacts. Internationally, the prevalence of pre-lingual deafness is about 7:10,000. The deaf NZSL

> community is estimated at approximately 4,500. In New Zealand prior to 1980, sign language was censured by schools and society as a means of communication. Intensive pedagogical focus on the mastery of speech was at the expense of a comprehensive education for many children. Deaf children tended to sign to each other and thus NZSL began as an underground language, which has developed through intergenerational networks of deaf people who claim a cultural identity. Today, human rights measures - particularly the United Nations Convention on the Rights of Persons with Disabilities have led the education system to recognise the importance of sign language to deaf people's access to society, yet not all deaf children have timely access to NZSL, and educational disadvantage persists for this population. (Witko, Boyles, Smiler, McKee, 2017 pg., 53).

While people are told they can request language interpreters for a number of languages in our health system, they are not typically informed they can request NZSL interpreters. This has consequences for the health of deaf people (their ability to understand what is going on in health appointments) the same way it would have consequences for the health of members of other cultural groups if interpreters were not provided for them to understand what was going on. This helps us understand the idea of deaf culture and the idea of our conceiving of NZSL as a language and not allowing this language difference (not disability) to disable deaf people when it comes to their health care and their education. The idea is that a fully inclusive society recognises and values disabled people as equal participants where their needs are understood as integral to the social and economic order and not identified as "special".

4.3 Statistical parameters

Statistics provides us with a way of describing and quantifying difference with respect to whatever parameters we choose to plug into our models. We can collect data on whatever parameters we like and run a variety of statistical tests looking for associations.

The relevant differences are between groups of people. To illustrate this, let us consider Jane and Joan who are identical twins who were born in Australia. Jane develops a rare form of cancer, or maybe Jane gets hit by a bus. While these are differences in health status these differences are between individuals rather than between individuals on the basis of group membership. Contrast Jane and Joan with Sarah and Adam. Sarah is born in Sub-Saharan Africa. Sarah will attends school for a few years and dies in her 40's. Adam is born in Sweden and attends schooling through to college dying sometime in his 70's. While these are, again, particular individuals, the idea is that this (or something like it) is the case for a significant number of people. Health outcomes (life expectancy) varies depending on country of birth and it is these differences between people on the basis of their group membership that is relevant to health inequity.

There are different kinds of variables in statistics. Sex, or gender, is typically regarded as binomial (either male or female and not both). Treating sex or gender as binomial means that statisticians have problems coping with individuals who are unwilling or unable to be classified in the standard box (due to genetic difference, gender identification, accident etc). On the other extreme a variable might be continuous in nature – such as birth date and time -that we render discrete in various ways We could render it discrete as an interval e.g., same day, same year, same 10 year block. We could make age to be a

binomial variable (e.g., under 30 years as at day/month/year vs 30 years or over as at day/month/year). Whether age is blocked in one or another of those ways may give us different results with respect to what our tests say about the association between age and some other variable. Or between a variable (e.g., a medication) and an outcome (e.g., no longer meets criterion for depression) once we have excluded certain people (e.g., people under 20 years and people over 50 years). Variables might also be continuous. For example, it might be the number of steps taken per day as measured by ones personal communications / surveillance device. The number of steps is nominal (let us say) there is a particular and discrete number of steps. One might measure the association between age and number of steps – or one might block one or both of them into coarser grained categories and look for associations between blocks. Different ways of grouping will give us different associations between groups. There is an art to grouping in various ways in order to find associations. For various ends.

In doing statistical tests one can do a 'one sided test' looking for whether there is an increase in x for an increase in y or a 'two sided test' looking for whether there is a difference (increase or decrease). Which tests we run affect which differences we might be able to find. If we aren't interested in discovering that an increase in a particular exposure is harmful – then we need not run a two sided test that could possibly reveal that it was. We have also learned that there are dangers extrapolating from adult age blocks, for example to children (e.g., antidepressants and suicide in teenagers) and perhaps at the other end dangers extrapolating to elderly people.

The point here is that statistics allows us to group or 'bin' people in various ways. It isn't the case that age or gender or indigeneity are objectively existing categories for us to discover information about. Let us just consider one more

example, the example of indigeneity. Firstly, we could group people on the basis of self report in answer to a question along the lines of 'which of the following ethnic / cultural groups do you identify as being?' and providing Māori as a selectable response. Alternatively, we could group people on the basis of self report in answer to a question along the lines of 'which of the following ancestry's do you identify with? We could be more explicit about this in (for example) requiring a 'verification of ancestry'. To understand how each of the above will select different people we need only consider that Māori have adopted people who are not ancestrally Māori and some ancestrally Māori people do not regard themselves to be culturally Māori. Whether Māori is a group that is self-selected or whether it is a group that is other-selected (and how it should be other-selected) is controversial. Sometimes the attitude has been that coders should over-ride individuals self report. For example, some ethnicity coders have reclassified self-proclaimed 'New Zealanders' as 'non-Māori' on the assumption they are middle class white Southern males intending to obscure discovery of difference in Māori populations in order to further benefit non-Māori New Zealanders (Cormack and Robson, 2010).

The statistical differences relevant are meant to be avoidable and remediable. To illustrate this the standard example is height. More particularly, stunting that is associated with malnutrition. If we find a statistically significant difference between the height of people of different ethnicity then if the difference is 'avoidable' and 'remediable' – e.g., by providing adequate nutrition to both groups – then the difference can be relevant for health equity. This is to be contrasted with people of different ethnic groups having differences in height that aren't due to malnutrition. Another example of differences that aren't equity candidates are differences in skin colour or eye colour. The differences that are relevant need to be avoidable or remediable. Genetic differences may or may not be. On the one hand certain groups can have dispositions to certain diseases – such as Tey Sachs disease. Technology might offer ways in which the disease is avoidable or remediable, however.

The differences are meant to be in determinants or in access to health related resources. This shifts attention away from health outcomes and into the things that are supposed to be the relevant causes of the differences in health outcomes. The Commission on the Social Determinants of Health (SCDH, 2008, pg.182) presents recommendations as to what data should be collected for the purpose of equity and protection of human rights. It is quite specific with respect to what groups the World Health Organisation considers to be of primary importance for equity consideration. Equity includes information on health outcomes stratified by:

> Sex, at least two socioeconomic stratifiers (education, income / wealth, occupational class); ethnic group / race / indigeneity; other contextually relevant social stratifiers; place of residence (rural / urban and province or other relevant geographical unit); The distribution of the population across the sub-groups; A summary measure of the relative health inequity... A summary measure of the absolute health inequity...'

Health Outcomes include:

> Mortality (all causes, cause specific, age specific); ECD [early child development], mental health; morbidity and disability; self-assessed physical and mental health; cause specific outcomes.

Determinants of health including stratified data on:

> Daily living conditions Health behaviours - smoking; - alcohol; - physical activity; - diet and nutrition; Physical and social environment: - water and sanitation; - housing conditions; - infrastructure,

transport, and urban design; - air quality; - social capital; Working conditions: - material working hazards; - stress; Health care: - coverage; - health-care system infrastructure; Social protection: - coverage; - generosity. Structural drivers of health inequity:

Gender: - norms and values; - economic participation; - sexual and reproductive health; Social inequities: - social exclusion; - income and wealth distribution; - education; Socio-political context: - civil rights; - employment conditions; - governance and public spending priorities; - macroeconomic conditions.

They also consider the consequences of ill-health can be economic and social. I am trying to convey the idea, here, that this is an awful lot of data that is supposedly collected in the name of surveillance for health and health equity.

The first section HEALTH INEQUTIES seems to be identifying the groups that are of 'special interest' as equity targets. While some seem to be global equity targets (e.g., women, indigeneity) there is scope for 'other contextually relevant social stratifier' for nations to identify their own minority target groups. The first section also introduces the idea of summary measures of health inequity including population attributable risk which as to do with the increase in prevalence that is attributed to group membership, otherwise known as the 'burden of disease' associated with group membership. I will have more to say about the role of statistical data later in the chapter.

The second portion on HEALTH OUTCOMES lists health outcomes thought to be relevant for inequity. Disability and mental health appear here and not as groups in the previous section and / or as determinants in the next section. This explains why some people do not think that disability is or can be a group of equity consideration. On the other hand, the flexibility in how groups are

defined does allow a community to, for example, regard people with a specific health status (e.g., HIV positive, history of mental illness) to be an equity group if they have concerns about injustice or human rights. For example, to consider how HIV positive status alters the determinants of health so as to promote worse health outcomes for people with HIV. I will consider people with disability as an equity group more in the next chapter.

The third portion on DETERMINANTS lists quite a range of variable to be tracked and reported on – and this is a report only on social determinants. The Dahlgren and Whitehead Model (1991) or the 'Rainbow Model' is another popular model of determinants of health that does not commit to the determinants being social. The model is similar to the World Health Organisation analysis and provides a nice visual summary of living and working conditions and how these wrap around individuals at the centre. The model is person-centred but the focus (for surveillance and intervention) are on the 7 categories (determinants) that fall under living and working conditions.

The ''General socioeconomic, cultural and environmental conditions' under which we have living and working conditions: agriculture and food production, education, work environment, unemployment, water and sanitation, healthcare services, and housing. Under that we have social and community networks. Under that, individual lifestyle factors. Under that the individuals with their particular age, sex and constitutional factors.

We have thus far considered data collection (in the name of health equity) and how data that is collected can tell us about differences between groups. We have considered that differences between groups can be magnified by limiting opportunities for variation in members within a group. We know that businesses use data typically for the purposes of increased profits. We know that

generally it is poor people and people who don't have the power to hide from data collectors that are the subjects for data collection. Poor people are rather more well studied than rich people. One might have concerns that 'vulnerable groups' are being targeted as objects of knowledge by people who are more likely to use the information obtained to further profit themselves at others expense than to genuinely assist members of minority groups.

The World Health Organisation considered that what equity groups have in common is that they lack the power to access health / the resources needed to access health. There are people who think that health is a resource that is limited such that it is not the case that all people can be healthy. They think that health is something that needs to be fought over and there will be winners and losers and obtaining health for themselves means undermining the health of others. Pollution needs to go somewhere, so better in other people's communities than one's own. We don't know whether certain levels of chlorine or fluorine or lithium or boron or oestrogen exposure are good, bad, or indifferent. If we are going to learn how better to pursue health then some communities will need to bear the costs of discovery.

4.4 Capitation funding and assessment of risk

In 'Why are we weighting? Equity considerations in primary health care resource allocation formulas' Crampton and Foley set out to examine New Zealand's primary health care funding formulas with respect to the 'equity implications of using different weighting variables in funding formulas (2008, pg., 133)'. More in particular, they set out to examine the relative merits of socio-economic variables (such as socio-economic deprivation and ethnicity) and health variables (such as measures of mortality and morbidity).

The authors consider that New Zealand tries to ensure equitable access to health care using funding systems based partly or fully on need rather than on user pays. They state that about 80 per cent of total health care resources in New Zealand come from government sources that are dispersed on the basis of particular formulas. Public funds are allocated to the 21 district health boards largely on the basis of the number of people within each board's region, with the per-head allowance adjusted so young people, old people, those living in socio-economically deprived areas, and Māori and Pacific populations receive a greater per-capita allowance (consistent with their greater need for health service). Further adjustments are made for rural populations and those with high numbers of tourists (Crampton and Foley, 2008, pg., 133-134). A proportion of this allocation is then passed to Primary Health Organisations (PHOs) using four related funding formula: First-Contact, Services to Improve Access, Health Promotion, and Care Plus.

The authors describe the ethical foundation of this to be grounded in the 1938 Social Security Act which they interpret as embedding utilitarian principles which place value on 'promoting overall population health gain - the greatest good for the greatest number - as reflected in the provision, in 1938, of universal tax-financed primary and secondary medical care, and prescriptions, free of charge to the patient (Crampton and Foley, 2008, pg., 133)'. They state that distinct from this is a commitment to distributive justice or fairness in resource allocation. They interpret this later consideration as being given expression in the needs-based (rather than user pays) approach and state that there has been much discussion in the economics literature on the concept of 'medical need', that is usefully defined as the 'capacity to benefit' from health care.

The state that 'at a population level, need for health care resources is related most fundamentally to population size, as well as the age and sex structure of a population. Over and above population numbers and age, it is not possible to encapsulate need for health care using any single population characteristic.

Hence the measurement of need frequently focuses on summary health measures, such as the mortality experience of a population, or when such data are not available or are considered unsuitable, on socio-economic measures.' And thus we have the population needs based approach to funding hospital and related services that was introduced in 1983 and has been the 'cornerstone of health service funding ever since, despite almost continuous restructuring of the health system (Crampton and Foley, 2008, pg., 135)'.

The authors describe how the Primary Health Care strategy set out a 10 year strategy (2000-2010) for improvements to primary care:

> Because one of the principle aims of the strategy was reducing health inequalities, the Ministry of Health recommended that additional resources be directed at those who have historically missed out on care (defined as Māori, Pacific, and those residing in deprivation decile 9 and 10 areas). Using deprivation and ethnicity in any First Contact formula was problematic for two reasons. First, there was not much evidence related to GP use by ethnicity and deprivation, and what evidence did exist indicated that these groups seek care at rates similar to the rest of the population despite being sicker (HURA Research Alliance *et al.* 2006; Scott *et al.* 2003). Hence, even if data could be obtained to support an allocation by ethnicity and deprivation, the resulting formula would cement in place historical inequalities and contravene the aim of the strategy.

It is hard to see why the authors think that providing DHBs and PHOs with more money to address the worse health outcomes of certain peoples would 'cement in place historical inequalities' unless one thinks that the authors are thinking that the primary beneficiaries of this approach are more likely to be non-Māori, non-Pacific, and wealthier than the lowest 20 per cent of socio-economically deprived. Perhaps the authors are thinking that if the money was

given to the people so they could purchase the healthcare they need, rather than to the DHB or the PHO to provide the treatment they think these peoples should have, then this would be more in keeping with the aim of the strategy and not cementing the historical inequalities.

The authors say in another section that the Care Plus funding formula analysis 'suggested that people with high needs either were not seeking care at the same rate or, once enrolled, were not being identified as having certain chronic diseases. Hence, the SIA weightings were applied to the Care Plus formula so as not to perpetuate historical inequities' (Crampton and Foley, 2008, pg., 138). So, the idea seems to be that the additional money is provided to DHBs and PHOs in order for them to better identify (and presumably go on to treat) people with certain chronic diseases, that they had not been identified as having, previously. In support of this we hear The Services to Improve Access (SIA) formula for 'Māori and Pacific enrolees residing in most deprived areas was based on 40 per cent of the amount by age and gender; with 20 per cent for those in less deprived areas with Pākehā enrollees in deprived areas also drawing a 20 per cent weighting (Crampton and Foley, 2008, pg., 137). The purpose of the risk-adjusted capitation is to 'ensure that plans will receive the same level of funding for people in equal need of health care, regardless of extraneous circumstances such as residence and level of income' (Crampton and Foley, 2008, pg., 138).

We hear that:

> The primary health care funding formulas currently in use all use socio-demographic variables as proxy measures of need. These variables have the huge benefit of being readily available and relatively cheap to collect. The ethnicity variable, however, has proved to be vulnerable to political challenges. In the lead-up to the 2005 general election, the question arose in political and public debates

> as to why both socio-economic factors (deprivation) and ethnicity factors (Māori and Pacific) were included in the primary health care funding formulas - the so-called 'race-based funding debate'. Ostensibly, the answer to this question is straightforward enough, namely that epidemiological evidence strongly points to the fact that Māori health status is not the result of poverty alone. The fact is that even when socio-economic deprivation is taken into account, Māori health status is poorer than non-Māori health status. Therefore, at a population level, Māori ethnicity is associated with need for health services over and above need associated with socio-economic deprivation. This in turn provides the rationale for having both deprivation and ethnicity in the funding allocation process: they are both needs factors that have to be taken into account (Crampton and Foley, 2008, pg., 142).

We then hear that potential disadvantages of morbidity-based risk adjustment include 'Adds to administrative complexity and may increase administrative costs, leaves a large proportion of differences in spending unexplained, and is not adequate in explaining expenditure associated with high cost disorders (Crampton and Foley, pg., 143). Also that 'most risk-adjustment systems are designed to allocate future resources and this allocation is based in large part on past utilisation. Where certain groups have under-utilised services in the past relative to their health need, formulas based on past use will cement in place current funding inequalities. It is largely for this reason that ethnicity was not proposed for use in the PHO First Contact formulas: the available evidence suggested that Māori enrollees consulted their GPs as often or slightly less often than their Pākehā counterparts after taking health status into account (in other words, Māori utilisation of services was low in relation to need). The single greatest challenge is to include in formulas variables aimed at explicitly reducing health inequalities (rather than perpetuating historical

funding patterns) (Crampton and Foley, 2008, pg., 145).

It is hard to make sense of this. The idea seems to be that Māori, Pacific, and socio-economically deprived peoples have worse health than people who are not of these groups. We know that there is a socio-economic gradient to health for all peoples - but that socio-economic status alone will not account for all of the disparities in health outcome for Māori and Pacific peoples. The Government is required to do something about this situation of inequality of access to resources needed to obtain health. Only, it is unclear that the resource that is lacking, here, is access to GP services. Timely diagnostic and treatment was mentioned, but these are often specialist rather than GP services.

Improving people's socio-economic position helps there health but the money wasn't to go to the people - it was to go to an infrastructure that explicitly says it is focusing on collecting data that is cheap and easy to collect and that potential downfalls of race and socio-economic based funding schemes are that there is additional administrative complexity and costs and leaves a large proportion of differences in spending unexplained. In other words, there is the potential for administrators to make a lot of money off of this bounty that has been placed on certain individiual's heads. Nobody seems to be expecting them to actually improve health outcomes - the extra money is because of past injustices. They aren't anticipating that these people will present to the clinics they are enrolled in any more frequently than other people do so they won't actually be seeking more GP contact. It sounds like a very attractive patient demographic for administrators seeking good remuneration. There does not appear to be any accountability on how the money is supposed to help the supposed primary beneficiaries. In answer to the question: Who is race based and socio-economically based targeting benefiting? The primary beneficiaries appear to be administrators. It is true the clinics are gaining more equity in

virtue of having these people enrolled in the clinics. This was not what equity in healthcare was supposed to be, however.

Consider the defence of race based funding offerd by Towns, Watkins, Salter, Boyd, and Parkin, 2004, pg., 5). They start with a description of how Māori health outcomes are worse than non-Māori health outcomes, even when we control for poverty. The authors argue that:

> Together, this evidence provides a compelling argument for specific initiatives focused on improving Māori health outcomes and reducing disparities. Contrary to the opinions of Dr Brash, current evidence identifies a need for health policies to continue to directly target Māori and further, aim to elucidate the barriers to care that presently exist (Towns, Watkins, Salter, Boyd, and Parkin, 2004, pg., 5).

They then go from the 'epidemiological argument' (that there are differences in outcomes) to the 'legal argument' that the government has a duty to target Māori as an ethnic group because of the Treaty of Waitangi:

> The arguments above [about differences in Māori health outcomes even when controlling for poverty] cite epidemiological evidence for targeting Māori as an ethnic group. However, there are other grounds, the most obvious of which is the Treaty of Waitangi... [that] represents the New Zealand Government's contractual obligation to explicitly ensure equitable outcomes for Māori (Towns, Watkins, Salter, Boyd, and Parkin, 2004, pg.,5)

The authors refer specifically to the third article with reference to 'equal rights' for Māori as being a relevant part of the Treaty, but they make no reference to the United Nations or to the Declaration of Human Rights that provides the

contractual grounding for the Treaty. Their argument for race based funding (against Brash) is summarised by them:

> Underpinning both epidemiological and legal arguments, are ethical principles. The central tenents of medicine (i.e., to reduce suffering, and to improve the quality and length of life) should provide a strong driving force to address these inequalities).

The authors do not consider ethical principles such as Māori being persons with right to health.

We learn that the idea of capitation funding is that District Health Boards and (as an offshoot of that) Primary Health Organisations should receive a funding allocation that is determined not only by how many people there are in the region, but that amount for each person should be weighted according to certain parameters about the person. For example, if the person lives rural then a certain amount extra for that person because of the higher cost involved in rural delivery. Older people and younger people also have higher health needs, and so an extra amount for those features of their demographic. Because Māori have worse health outcomes than non Māori District Health Boards should also gain an extra amount for these people. This is the idea of capitation funding - the idea of funding per person with an adjusted amount on the basis of such factors as their age and ethnicity. The idea was that because health outcomes are worse for Māori (but we have a duty to work to change that because of history / the Treaty) the government should give DHBs and PHOs more money for having Māori people. Presumably, because these extra funds were supposed to be used to achieve better health outcomes for Māori.

It is interesting that the justification for capitation funding (more funds for Māori) was that health insurance companies already make use of such informa-

tion in calculating risk. The issue here is that making use of such information in calculating risk is something that is placed back on the individual with respect to the premium that the individual is expected to pay in order to purchase their health insurance. Health insurance is supposed to be a way of distributing risk across populations. The idea is that by paying a smaller amount towards a general pool there will be enough in the general pool for everyone who contributed to it to draw from if they need to claim on the things they have been insured for. The issue is one of calculating how much each individual should contribute to the pool so the distribution of risk across the insured population is fair. If my pre-existing risk of developing cardio-vascular disease is twice your risk then it may seem fair that I contribute more to the pool. On the other hand, I didn't choose my pre-existing risk and calculation of individual risk is a tricky business. What sorts of factors are useful with respect to the prediction of risk?

It strikes me as obvious that while there might be associations between factors like race, ethnicity, gender, religion, high medium or low cost of ones first car, secondary school attended, mesh block unit at birth and health outcomes it would be discriminating against people to charge them higher premiums because of factors such as these (and indicators thereof e.g., with the first car as a proxy for socio-economic level during childhood because of the association). Charging people higher premiums for their membership in supposed 'equity groups' is a way of discriminating against them. This should not be allowed as accceptable practice. By insurance companies. And not by governments (for the supposed benefit of the disadvantaged) either.

We have seen how Brash's response to capitation funding (where the idea was to provide DHBs and PHOs more money to treat Māori populations) was to say that health care should not be race based. It is possible to agree with

Brash on this (as I have done) without denying that Māori have worse health outcomes and without denying that this is unjust and without denying that more should be done to achieve equity for Māori.

What were the PHO clinics going to do with this extra funding they get for enrolling Māori? We learn that Māori don't actually see their GPs any more than non-Māori (so it wouldn't cost more to provide GP services to Māori). We learn that there is no reason to believe that if Māori saw GPs more frequently there health would be better (so they don't plan on spending the money on providing more GP visits to Māori). Rather, we hear that Māori are going to be encouraged to see non-GPs more (allied health professionals instead of GPs). That there will be special clinics set up for Māori and poor people because capitation funding has put a bounty on their heads where clinics can earn more money off of providing less services to these people when nobody expects a better outcome for them.

Chapter 5

Equity targets and empowerment

5.1 Distribution of benefit

Earlier we considered the United Nations view of human rights and, more particularly, of the human right to health. At the time I raised some objections to the UN. Mostly along the lines of it being a nice ideal in theory - but it was something that was thought or felt to be very far removed from the realities of life. People seem to have been encultured to believe that life - real life - as in 'this is how the sausage is made' and as in 'you are a grown up now, and it's time to grow up from these childish ideals'. That life: is thought to be more like such obviously adult shows as *Game of Thrones* or *The 500*. The thought here is that there really is a struggle between different groups, or factions, and to that end people make bargains and deals that are kept only when it is expedient for them to do so. These shows are sometimes discussed as being 'morally grey' in the sense that there isn't a clear division between 'good guys' and 'bad guys'. Rather, the idea is that all of the people are playing the very same game of keeping their promises only when it is expedient for them to do

so.

What seems to be thought to justify this as a *moral* position - where our heroes are able to behave pretty badly towards others and yet still be presented as heroes - is the notion that everybody is playing the same game. On this view, when one is faced with the losers in life (those who lack access to resources they need) one can console one self that if they had have been lucky enough and / or smart enough to have seen the opportunities that one did - to lie, cheat, and take more than ones fair share - that they would have done this. In other words, those who have more than their fair share can justify why this is acceptable by saying that those who have nothing would have done the same to them if they could have gotten away with it. In other words, the losers in life can look at the wealthy and say 'there but for the grace of god go I'. They wouldn't be doing things differently if they had the luck and / or talent and / or opportunity of those who are considered to be the 'winners' in this game of life.

It is surprising to me that many people do seem to credit something along the lines of the above view. A diversity of people. Rich people, and poor people. Black people and yellow people and white people. The problems with this view of life, however, is, I maintain, that it results in a world that is worse overall than a world where more people adopted a stance of fair trade and co-operation for mutually shared benefits would be.

The same story again, consider two different approaches to trade. One view of trade is that it is something that is, or that should be, for the mutual benefit of both parties. The idea, here, is that trade is good for both. Another view of trade is that one should aim to take more that ones fair share - if one can get away with it. If one can convince the other party that what one is bringing to the table is worth considerably more than it is, then one would

be a fool for not rising to this opportunity. It isn't like (the assumption is) the other person is trying to conduct their business any differently. The view might be that this is trade and this is what trade is, and should be, about. It should be understood that each party is trying to persuade the other of the immense value of what they bring to the table and is trying to persuade the other that what they bring is of less value. Of course the idea of value, here, is an interesting one. Partly how much something is worth is determined by how much people are willing to pay for it. If people believe that Auckland real estate is scarce, for example, such that there are an excess of buyers willing to pay asking price (and financiers willing to finance them) then this boosts the amount that buyers will be willing to pay for houses in Auckland.

This view of trade where one should take more than ones fair share if one can get away with it is a game that results in a world that is worse off than what would be the case if both parties tried to come to a fair, and mutually beneficial deal. Consider the amount of energy and effort that needs to go into trying to con the other party and trying to figure out what the other party is up to. Consider the amount of energy and effort and expense that has been diverted from genuinely productive behaviour. While it might inspire a television drama with all the intrinsic fascination (and moral education) of such a show as *Shortland Street* it seems fairly clear that without the infrastructure producers simply cannot go on producing. There is not really incentive for producers to produce when they do not get to bear the fruits of their labour. When the talented youth does not have his intellectual property respected (e.g., in a carving) then there is little incentive for them to go on to produce and so the people stop producing arts and culture such that we might bring such things to a free trade negotiation and be a more desirable trading partner.

Of course if you can get people to believe that they need to produce such

things (for others to trade and get rich from) in order for them to have basic things like enough food to feed themselves and their kids, accommodation where it feels safe for them to walk down the street, then why wouldn't you - if you can get away with it? Maybe you can inspire them to work out of fear. This position might seem attractive if you thought that those very same people stuck in the unhappy and unhealthy neighbourhoods would do the same to you if they had opportunity to put you there, instead. Why not just take what you can from New Zealand and rely on Family Trust (for yourself) Charitable Trust (for yourself) private hospital (for yourself and then, once you've made your fortune for the 'Other'), then take your profits and go retire into some other nations Superannuation Scheme? Why not - if you can get away with it.

5.2 Benefit grounded in human rights

Consider a Treaty as something along the lines of a trade deal. The intention of the Treaty of Waitangi was presumably for there to be mutual and approximately equal benefits for both parties to the arrangement. If the intention wasn't for mutual benefit then nobody in their right mind would have signed it. The United Nations puts the rights of peoples as a pre-condition for Treaties. It is because of this notion of peoples having rights - rights to health and education and resources needed to attain such things that grounds the idea of people being true to their word about deciding to mutually pursue peaceful co-existence rather than pursuing a path of an attempt at annihilation. The choice was made to uphold the rights of the indigenous peoples of New Zealand including their claim to health and education and resources needed to attain such things. The intention of the Treaty wasn't to try and con Māori into giving up their rights or to con Māori into believing we were working to uphold their rights but actually taking every opportunity to take what the settlers could, when they would, at the expense of Māori for their own unequal benefit.

There has been criticism of the Treaty Settlement Process insofar as it is based on a capitalist economic model of resources. There has been much criticism of capitalist economics, more generally, and particularly with respect to the commodification of such things that are not supposed to be for sale. Things that are not supposed to be in limited supply such that there always will be losers who miss out on their attainment. Such things as the resources needed to attain health e.g., healthy housing, clean drinking water, access to healthy (nutritious / nutrient dense) food etc. A Treaty Settlement process that offers x amount of dollars in reparation or y amount of shares in z business has been criticised as a process that has not contributed much for the attainment of human rights for a greater proportion of Māori.

Above, we considered the view of life as being a situation where you should aim to take what you can for you and yours for as long as you can because you can. This view isn't restricted to people of particular sex or gender or gender identity or disability or race or colour or creed or religion. It is a view or a strategy that some (perhaps most) people in all of these groups (and many besides) have adopted. Instead of being a psychopathic view it is sometimes portrayed as a grown up view with an appreciation of the complexity of moral decision making in the real world and a maturity to embrace greyness. The justification for it as a moral view is that this is the game that others are playing and if one wins while others lose one can console oneself with the knowledge that the losers would be congratulating themselves on their victory if the positions were reversed.

If the Treaty of Waitangi was a treaty where the idea was to work together when it was expediant and con and lie and swindle when that was expedient then perhaps we can just say that Māori appear to be losing. It may well be

true that some or even most Māori would console themselves with precisely this if the situation had have been reversed and there was calculated to be worse health (education etc) outcomes for non-Māori than Māori in society today. I suppose the greatest indicator that this is so is to look at the inequalities that exist within Māori peoples. While it is true that the elite non-Māori generally earn more than the elite Māori, it is also true that there is a considerable inequality between the highest paid Māori and the most deprived Māori. If some elite group of non-Māori are biasing things in their favor with respect to the rest of their peoples, then one view of equality would be a situation where Māori similarly have an elite group of Māori similarly biasing things in their favor with respect to the rest of their peoples.

This brings us to the issue of different notions of equity and what equity looks like. We can agree that equity has something to do with fairness. One way of considering equity as fairness is to consider inequalities that exist between Māori and non-Māori. Another way of considering equity as fairness is to consider inequalities that exist between the highest wealth and the lowest wealth people. With respect to the equitable development of health and education for Māori, one might think that equity for Māori is when the kids of the elite Māori have the same opportunities for training (for example) as the kids of the elite non-Māori. If rich white people have opportunity to hide assets in trust funds, for example, then there should also be rich Māori people which similar opportunity to hide assets in trust funds, for example.

Of course when one considers equity within Māori (similarly to when one consideres equity within non-Māori) it seems hard to credit the people who have an excess of the resources they need crying that they still don't have enough (e.g., that chief excecutives or the politicains or the government advisors in the United States or the UK earn more than the chief executives in New Zealand;

that the non-Māori chief executives or the non-Māori politicians...) when they seem to have this view that it is okay that they have so very much more than the rest of their people - because their people would similarly be focused on the top and on getting more – if the situation was reversed. In other words, they are holding a 'there but for the grace of god go I' position to justify their having more than the people beneath them, but crying foul and injustice - *and expecting that to have weight in the name of equity* when those above them have more.

This position appears to be hypocritical, in other words. Which is another way of saying that it does not appear to be rational. Fortunately, there is an alternative. As an alternative we can consider that the source of the Treaty and the source of our concern with equity lies not in a trade deal where different parties were each trying to gain the upper hand over each other. It lies not even in a trade deal where some small segment of each of the parties decided to genuinely work together in order to mutually screw over the majority of each of their peoples. Instead, the source of the Treaty lies in the notion of fair trade between people who are equal in the respects that matter in the sense that they are persons with human rights who are pledging to uphold human rights and live in peace and prosperity for the good of all. The alternative would be for people to focus on taking what they can get for as long as they can get it because they can get it - which is best exemplified in overt war. This later game of life has no recourse for people to cry 'foul! – in the name of equity!' however.

5.3 Pascal's Wager

What shall we then say to the critic who still needs some persuading to drop the game of risk where life is nasty, brutish, and short for a great proportion

of us, and start playing a game that seeks for mutual benefit and upholding of human rights. One way to look at it is in terms of something along the lines of the pay-off structure for Pascal's Wager. Pascal's Wager was about whether it was rational to believe in the existence of God. The idea was that there are two ways the world could turn out: God exists, or God doesn't exist. There are two ways one could believe the world to be: One could believe in God or one could not believe in God. Pascal then describes something like the pay-off structure for these 4 possible states of affairs.

The first is where you believe in God and God turns out to exist. This is the best outcome. The rewards are infinite (assuming believing means you get infinite rewards in heaven). The second is where you believe in God but God turns out not to exist. Pascal thought ones life would be a bit the worse off for time spent preying and reading the bible and the like, but ones life wouldn't be so very much the worse off for this mistaken belief. The third way things might go is one does not believe in God and it turns out God doesn't exist. One might think that this situation is one where one's life is a little better than the previous in not having ones time wasted carrying out religious rituals. Lastly, one might not believe that God exists, and one might turn out to be right about that. Pascal thought the payoff for believing and God existing was infinite reward but the payoff for not believing and God existing was infinite harm / damnation. The other ways things might go are both finite so sort of pale into comparison. He thought this showed that it was rational to believe in God.

Many problems have been pointed out with this argument for the existence of God. Most significantly, if the notion of omni-god is internally incoherent or contradictory then God cannot possibly exist - in which case we know the odds of God existing is not one out of two, rather it is precisely zero. Another problem is how this notion of believing is supposed to be related to the the

notion of infinite reward. How plausible is it to believe that believing will result in infinite reward? While it might seem that the odds are more than 0 in which case infinity trumps all, many have resisted Pascal's Wager when it came to their being converted to believing in something roughly along the lines of omni-god (all knowing, all powerful, perfectly benevolent).

The idea of pay-off structures is an interesting one, though. Much work has been done on models of co-operativity, for example, and different co-operative strategy and the pay-offs for different co-operative strategies in encounters with other players (e.g., prisoners dilemma type games). What I want to consider, here, is whether it is rational to believe in something along the lines of the UN's view of the world as being one where mutual co-operativity is the goal or the aim or the best way for things to be. This is as opposed to something along the lines of the other view of the world as being one where players should pursue their own self-interest and merely coincide or co-ordinate their behaviour when it is expedient for them to do so.

If we pursue co-operativity and are screwed over by non-co-operators at least we can say that we tried. At the end of the day, one can only be responsible for ones own behaviour. If we pursue co-operativity and are met by other co-operators, everyone wins. If we fail to co-operate and are met with like-minded individual's then we might strike it lucky in life (temporarily - until the losers wise-up) or we might not (in which case we don't have rational recourse). If we fail to co-operate and are met by co-operators then we can console ourself only with the knowledge that our very own lack of apprehension has contributed in making this world so very much worse, for us all.

5.4 The Original Position

Instead of trying to understand how morality could have evolved out of a state of nature, we can concern ourselves with how morality can arise in people in response to their apprehension of something along the lines of the original position. The idea is that we can't really explain how morality evolved – but we can explain how our cognitive capacity and empathy evolved and our cognitive capacity and empathy then allows us to apprehend such things as triangles, and also such things as the original position. And then we can choose to work towards the realization of various things, including the view of life, that follows from that.

The original position was described by Rawls as a thought experiment to help us clarify our moral concepts of justice. The original position involves our apprehension of impartiality of judgement and equality of persons. The original position is a situation that is fair among all parties to a social contract. The idea is that if the parties are fairly situated and take all relevant information into account then the principles they agree to and the laws and institutions required by the principles will also be fair.

On Locke's version of a social contract people know everything about themselves including information about their natural talents, racial and ethnic group, social class and occupations, level of wealth and income, their religious and moral beliefs, and so on. The problem is that these factors are not good reasons for depriving people of their equal political rights or opportunities to occupy social and political positions or for positions involving governing or administrating society. Socially powerful and wealthy parties can rely on knowledge of their "threat advantage" to extract favourable terms from those in less favourable positions which introduces bias.

This avoidance of bias is why Rawls situates the parties to the social contract so they are under a veil of ignorance with respect to factual knowledge that can distort their judgments and result in unfair principles. He claims it is essential that no one knows his place in society, his class or social status, his fortune in distribution of natural assets and abilities, intelligence, strength, and so on. This veil of ignorance is designed to be a strict position of equality that represents persons purely in their capacity as free and equal moral persons. They have their higher order interests in common in developing the moral powers of justice and rationality, their need for primary social goods, and so on. This veil allows people to deliberate on the basis of equal respect for moral persons. While Rawls was clear that the original position is not supposed to be a statement of historical event – it is not the story of the evolution of morality or even of the history of morality - we might do well to consider how we can remove discrimination from selecting people into certain positions or training programs, in society.

For example, we might consider that Medicine is an institution that is required for co-operative society. Medicine relies on co-operation from the people. People allow their infants to be injected with immunizations trusting that Medicine is helpful for them and their people and Medicine is not exploiting them and their people for the benefit of some other group of people. Similarly, people donate blood and organs because they wish that blood and organs may be available to them and their people, should they need them. If it were discovered that the primary donors were a group of people significantly different from the primary recipients, then this would go rather a large way towards undermining public trust in Medicine. If it were found, for example, that most of the blood were shipped to Australia or made available to private clinics rather than public hospitals. People present to GPs trusting that they will

be referred on for appropriate tests, procedures, and medications and not be regarded as a control group or be merely observed and their data collected in the name of Medical treatment. People provide blood and other tissue samples for analysis trusting they will be informed if abnormalities are found, and that Medical treatments may be available to them in a timely fashion. If it turned out that samples were being collected so Medicine could learn from them - but that Medical treatments were only going to be provided to some other group of people then this would again undermine peoples trust in Medicine and it would undermine the public co-operation for the continuation of Medicine and Medical Institutions.

Medicine (Medical Institution) wants all the people (particularly the poor people) in society to hand over their babies for immunizations. Medicine wants all the people invited to provide samples (blood, tissue, tumour) when requested. Medicine wants people to have procedures (colonoscopy, cervical smears, mammogram) when requested. Medicine wants a diverse range of people to provide blood for transfusion and organs for donation for greater supply. Medicine wants fairly much exclusive prescription powers. Medicine wants exclusive autopsy powers with respect to the dead (and presumably also with respect to the recovery of intellectual property implanted devices). Medicine needs to realize that if Medicine wants the people to come to the party in this, that, and the other respect – then Medicine has certain duties to the people. It is only because the people trust Medicine that they allow Medicine to have the status that it does. Medicine has a duty to ensure the infrastructure is in place such that Medicine is worthy of that trust otherwise Medicine is not sustainable.

One of those duties is to make sure that Medical treatments are equitably distributed. Another of those duties is to make sure that Medicine itself (as an

institution) is as diverse as the people Medicine expects to do what it is that Medicine asks of them. If Medicine wants to particularly target a certain segment of society (e.g., by having the majority of people requiring / requesting treatments being Māori, Pacific Islander, disabled etc) then Medicine needs to accept a similar level of representation amongst it's ranks. This is the rational position. An equitable position. A just position. It relies on a certain amount of empathy, however, with respect to the ability to grasp different positions in society and figure out a way (an equitable distribution) that works for the greater benefit of all. This position is required if Medicine wishes to persist as an institution. If it is for the benefit of only a small few then it is not sustainable, and people will start realizing that they actually do not have access to Medicine – it is Medicine that has access to them – and this is not a fair or co-operative situation. The idea of the original position involves people making a commitment to justice. It is a rare person who can feely and without resentment sacrifice his or her life prospects so that those who are better off can have even greater comforts, privileges, and powers. This is not a just thing to expect of people.

Some have criticized the veil of ignorance required for the original position as being something that is not psychologically possible. We can consider how it is psychologically possible to eliminate discrimination from selection algorithms, however. We start out with the desired outcome: A representative selection. We then tweak the algorithm until it delivers our desired outcome. People have been doing this already to achieve their desired (sufficiently biased) outcome, why not employ that same technology for the good of more of us?

5.5 Birthright to the 'upper hand'

In 2004 the New Zealand politician Don Brash (as leader of the opposition) gave a speech to the Orewa rotary club where he stated that 'We are one country with many peoples, not simply a society of Māori and Pākehā where the minority has a birthright to the upper hand'. He also said that 'in both education and healthcare, government funding is now influenced not just by need - as it should be - but by the ethnicity of the recipient'. Brash's speech was a response to the capitation funding that we saw in the last chapter. The typical response in the literature has been to defend capitation funding on the grounds that it helps Māori and that Māori need a little help. I am interested, here, to focus on this idea of a minority with a birthright to the upper hand, however.

Poole, Moriarty, Wearn, Wilkinson, and Weller (2009, pg., 91) describe that:

> Up until about 20 years ago, the predominant medical student characteristics were being white, male, coming from a higher socio-economic group, and having university-educated parents, including one in eight with a parent in medicine.

In 2001 there was a New Zealand Wellbeing, Intentions, Debt and Experiences (WIDE) survey of medical students (Fitzjohn, Wilkinson, Gill, and Mulder, 2001). 258/1377 reported attending a private secondary school for the bulk of their schooling and 164 reported an integrated (previously private but now partially public) secondary school. 242/1380 report at least one parent who was a medical practitioner and 43 students reported both. We were told the survey results may have been biased because some permanent residents did not participate due to believing it to be a survey of debt (which they didn't have)

We hear that:

> internationally there have been calls for medical schools to provide more evidence of their impact on the public good. One aspect is the expectation that the population of doctors reflects the social and ethnic diversity of the community it serves (Pool, Moriarty, Wearn, Wilkinson, and Weller, 2009, pg., 91).

The rationale for diverse representation, as they see it, is that:

> This expectation is underpinned by two main principles. The first is based on social justice and equity of access for minority groups; the second, because of a diversified student population may be more disposed towards addressing priority areas of need (Pool, Moriarty, Wearn, Wilkinson, and Weller, 2009, pg., 91).

We also hear that:

> In both NZ schools there are over three eligible applicants for every one place offered. As such, decisions may be based on very small differences in scores, and many who would otherwise be fine doctors are declined entry (Pool, Moriarty, Wearn, Wilkinson, and Weller, 2009, pg., 91).

So we have the issue of how to select which of the applicants shall be determined to have applications that are successful in a way that mirrors diversity in society.

5.6 The peoples of the health system

There is some controversy over what we should call the people who use the public health system. They were traditionally known as 'patients' - because they had to be patient, when it came to issues of their treatment, fairly clearly. They have more often come to be known as 'clients' or 'consumers' by managers and administrators, however. Partly, as we have come to adopt a more standard market-place view of health-care as something to be purchased (whether by individuals, individual's insurance companies, or by the state). Calling them 'citizens' would emphasise the fact that they are citizens, too, with rights and duties of good citizens the same as the people who are making the decisions when it comes to the running of our health system (even when the people making the decisions when it comes to the running of our health system prioritise health insurance plans for themselves). I have finally come to the view that they are best regarded as 'peoples', however. I have come to understand the notion that the health system must be people-first or people-centred. I did not understand before that citizens have duties to the government, whereas governments have duties to the people.

5.7 Inclusion and empowerment

We have seen already that medicine plays a role in determining who is and who is not disabled (and in determining what kind of disability they have). Medicine also plays a role in determining what disability status amounts to - with respect to predicting likely futures. While judges are supposed to assess capacity and juries are supposed to assess intent, medical doctors may be called on to provide expert witness as to mental state or mental status or to physical capacity or incapacity - both to help judges decide, and also to assist with juries. It is important to remember that an early use of medical

diagnosis - of feeblemindedness or mental disorder - was to render a person *illigitimate*. For example, if the first born son was feebleminded or mentally ill then it would be *equitable* if the judge were to deliver a verdict (in response to expert medical testimony) that the estate be returned to the family. Perhaps to be transferred instead to a second born son (if there was one). Or failing another son maybe even a woman. A daughter, or perhaps a mother.

We can see something of this still when we consider the *Division of Health Sciences Declaration and Police Vetting Forms* That applicants are required to fill out at time of application for Professional Practice programmes. The form consists of 3 components: A 'Health and Conduct Self-Declaration', 'New Zealand Police Vetting Request' and 'Declaration of Immunisations and Infectious Disease Status'. 'The Division of Health Sciences requires all applicants applying for any of its eight health professional programmes to declare any criminal or disciplinary charges they have faced, or are facing, and any health status issues which could affect their participation in clinical aspects of the programme or their overall fitness to practice.' The form clearly states 'if you are in doubt concerning the appropriate responses to the questions in this section you are strongly recommended to seek advice from the Admissions Office and / or appropriate registering professional body. Failure to declare any relevant matter may lead to your exclusion from any programme of study for which you are accepted.' In other words, ones responses to the questions on the forms may be used to exclude applicants from selection into Professional Practice, including Medical Program.

With respect to 'Fitness to practice' declaration people are asked 'Have you ever been diagnosed with, or assessed as having a health condition or impairment which may either limit your ability to undertake the requirements of the programme, or which may require adaptations to the work place or work procedures, to enable you to undertake the requirements of the programme in

a manner which is safe for you and others?' The form continues 'if yes, please give details below, including any accommodations that would be required to enable you to undertake the programme of study. Note: It is important that this section is filled out correctly and truthfully. Failure to declare any relevant matter may lead to your exclusion from any programme of study for which you are accepted. The information will be used to ensure all successful applicants are provided with the appropriate support. You may seek advice from the Admissions Office or the University's Manager of Disability Information and Support who will, if necessary, act as an advocate or facilitator in your interest.'

The concern here is that while applicants are assured that the information will be used to assure that 'successful' applicants are given the support they need, they are not requiring this information from 'successful' applicants. The University requires this information from all applicants and it seems that they think this information is relevant for determining which of their applicants they will decide are in fact 'successful'. Applicants are not told that they may be advocaters or facilitators in their own interest (i.e., they are not told that they will be contacted if the University is in the process of making a decision to exclude them) or that they may select who it is that they wish to represent their interest (e.g., a human rights lawyer). Rather, the focus here is entirely on exclusion and disempowerment.

We can consider that this is a situation in which it is perfectly possible to adopt something along the lines of the Original Position by simply not asking applicants to supply this information prior to being informed that their application has been successful. The only grounds the University should have for collecting this information prior to deciding which applicants to consider or further process is if they were going to sit it to one side until after candidate ranking and then employ it as a second step as a weighting to achieve the diversity of outcome they desire in their Medical Student population. But

this is not how the algorithms are developed. We need to ask: Who are the primary beneficiaries of the algorithms at present?

With respect to the police vetting form applicants are informed the police will be asked for 'information regarding family violence where I was the victim... Or witness... primarily [but not restricted to] where the role being vetted takes place in a home environment where exposure to physical or verbal violence could place vulnerable persons at emotional or physical risk.' In other words, the University of Otago considers it appropriate to discriminate against people who have had previous experience of victimisation / who have witnessed victimisation. This policy seems to allow the university to discriminate against refugees and people of lower socio-economic status who are more likely to have been previously labelled as 'victims' by police or social services in New Zealand.

With respect to the 'Declaration of Immunisations and Infectious Disease Status', again, in order not to discriminate against applicants on the basis of their Health Condition the University should not ask or seek this information about applicants prior to their selection. All applicants should be informed about requirements for all students who take places to have immunisations and to have check-ups with respect to disease status including information about who should be notified and treatment regimes that are required to be adhered to for fitness to practice. This would capture the concerns with respect to potential harms to patients. Asking this information prior to applicants being selected when the information will only be used to exclude applicants from having their applications considered / accepted is not appropriate.

We need to get clear on two steps: Firstly, we need to stop discriminating against people. Secondly, we need to look at what inequalities remain and adjust our selection algorithms so as to produce what it is that we require: Sustainable Medical Schools and Medicine that is sustainable for a greater proportion of us. We don't need to collect another 10 or 20 years worth of

data to undertake the first step of that process. We can look at the diversity of applicants and the diversity of the applications that have been selected to ensure we aren't doing what we've always done in furthering the interests of the elite minority.

We are not provided with the percentage of Māori and Pacific Island applicants who are *declined* entry to Medicine. We are told that at Auckland there is 'the exception of a small number of students included or excluded directly as a result of interview performance', however (pg., 90-91) and the implication seems to be that Māori and Pacific Island students interview better than non-Māori and Pacific Island students - but it is unclear why we would think this since there is much evidence that interviews tend to select against such students and interviewers are more likely to select applicants who appear similar to themselves and we have already learned how there is a significant lack of diversity in Medicine (and in interview panels for interview for Medicine). We are not told who the primary beneficiaries are of this veto ability of interviewers.

It is unclear who the primary beneficiaries of 'Rural Origins' policies are because we are not provided with the socio-economic status information about those applying compared with those accepted in under that category. It isn't so terribly far-fetched to imagine Medical Doctors choosing to send their kids to private boarding schools in rural communities, for example. There isn't a shortage of General Practitioners in Central Lakes district, I wouldn't think. We need to bear in mind who the primary beneficiaries of equity policies are supposed to be and be mindful of people who think it appropriate that they take the upper hand (in the name of equity) - if they can get away with it. We don't need several generations of observational study to know the effects of discriminating against candidates on the basis of disability, ethnicity, and socio-economic status when it comes to the development of the New Zealand Health System. The system is unsustainable. It is a shame people haven't

decided to invest in better futures for more of us.

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