Achieving Equity in Health Outcomes

Summary of a discovery process

Te Kāwanatanga o Aotearoa

MANATŪ HAUORA
MINISTRY OF HEALTH

Acknowledgements

This report would not have been possible without the generosity of all the people we engaged with, who gave their time, and shared their experiences, expertise and manaakitanga (hospitality).

Through the engagement process, we were in awe of the indepth knowledge these people held, and their commitment to the communities they serve. We witnessed a high level of commitment to working towards a more equitable future, throughout the health and disability system and the wider public sector, and an optimism for achieving our aims.

The Ministry of Health would like to thank all the people who gave their time and insights.

This document is available at health.govt.nz

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Having a common understanding of equity is an essential foundation for coordinated and collaborative effort to achieve equity in health and wellness. The definition of equity used in this report is:

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

For more information on how we arrived at this definition please see page 7.

Introduction

In 2018, the Ministry of Health initiated a work programme on achieving equity in health outcomes. Specifically, this programme aims to ensure that equity is at the heart of the way New Zealand's health and disability system operates and to promote the cultural shift needed to achieve that.

This report provides a brief summary of phase one of the Achieving Equity Work Programme: The Discovery Phase. The aim of the discovery phase was to identify where practical and coordinated effort could be undertaken to achieve a measurable shift in health equity in the next three to five years. Through an examination of the literature; a review of evidence; and consideration of what people said needs to be tackled in the health and disability system, common challenges and opportunities for achieving health equity in Aotearoa/New Zealand have been explored.

This report is a condensed summary, rather than a record of all the points canvassed or discussed. Further information on the methods employed in this phase can be found in the 'Discovery phase methods' section below.

The insights gained through this phase of the achieving equity work programme contribute to a shared understanding of challenges facing the health and disability system in addressing health equity. These in turn highlight opportunities for further collaboration and coordinated practical action.

The next phase of the equity work programme will support an integrated collaborative whole of system approach to achieving equity. The next phase will increasingly respond to the health aspirations of Māori in accordance with our obligations under Te Tiriti o Waitangi (the Treaty of Waitangi) and will focus on the matters raised in the Waitangi Tribunal's recent report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (Waitangi Tribunal, 2019a).

> 'The 'inverse care law' states the availability of health care varies inversely with the population's need for it; in effect, those most in need of health care have the least access to it.'
>
> Hart 1971

Background

Addressing equity has a long history in health in Aotearoa/New Zealand and internationally. The concept of health equity was strongly endorsed by participants in the World Health Organisations (WHO) Conference on Primary Health Care in Alma-Ata in 1978 (WHO 1978). In the years following the Alma-Ata conference, the WHO has undertaken several global initiatives to focus the attention of governments on health equity. Academics, clinicians and health and policy researchers in New Zealand, have written about health equity or health inequalities for almost four decades. While there have been specific initiatives to address health inequities and incremental improvement in reducing health disparities, avoidable differences in access to and experience of health care and health outcomes between groups of people remain. Many Māori remain significantly under-served by the health and disability system.

Pacific people and people living in low socioeconomic neighbourhoods also remain in the most disadvantaged groups.

Health and wellness exist in a complex system. To a certain extent, they depend on factors a health and disability system is able to control, but they are also impacted by the various social, economic and behavioural determinants of health. In the almost two decades since the Public Health and Disability Act 2000 explicitly made removing inequalities an objective of district health boards (DHBs), we have made some progress but there is still much to do. One of the most obvious examples of this is the clear discrepancies in life expectancy at birth for various population groups, as Figure 1 shows.

Figure 1: Life expectancy at birth, by gender, Māori and non-Māori, 1951–2013[1]

Source: Ministry of Health 2018a

The Ministry has committed to 'delivering the Government's goals of a strong public health care system and improved and more equitable outcomes for New Zealanders' (Ministry of Health 2018b). The Ministry is now integrating a focus on achieving equity in health and wellness across its work programme and sector accountabilities. It has charged its new executive-led Outcomes and Equity Committee with governing ongoing efforts in this area. The Committee's role includes oversight, accountability and key decision-making in terms of the equity and outcomes components of the Ministry's stewardship role at a system and organisational level (Ministry of Health 2018c).

Te Tiriti o Waitangi

Te Tiriti o Waitangi (the Treaty of Waitangi) provides an imperative for the Crown to protect and promote the health of Māori. For the purposes of this document, the

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[1]   Adjusted life expectancy estimates for Māori 1980-1999 use estimates from the New Zealand Census – Mortality Study (NZCMS) graphed at the mid-point of each time period. From 2001, adjusted estimates are close to unadjusted.

Crown has a responsibility to respond to Māori health aspirations and meet Māori health need. Figure 2 reproduces a diagram developed by the Health Quality & Safety Commission. It is a useful depiction of the interrelationship between these two responsibilities.

Figure 2: Supporting Māori health aspirations and equitable health outcomes
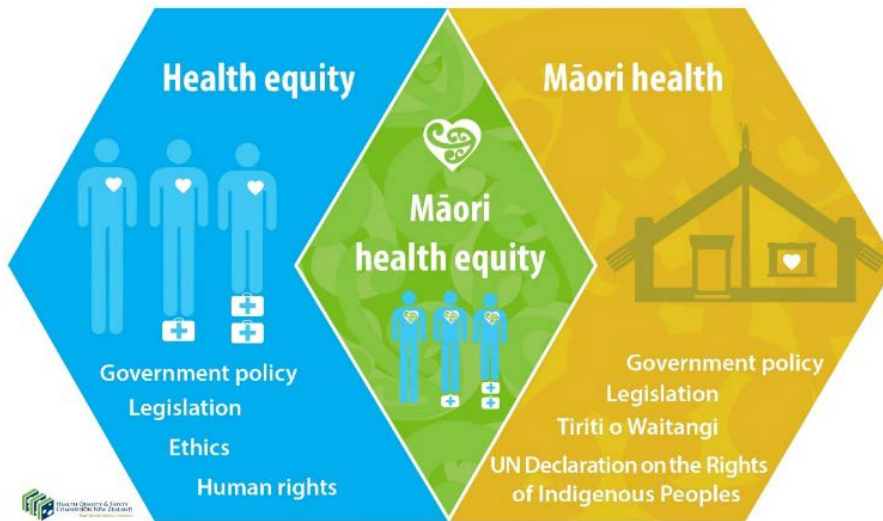
Responding to Māori health aspirations is Te Tiriti o Waitangi obligation and includes achieving equity for Māori. Within a Te Tiriti o Waitangi framework, delivering on the rights and needs of Māori people is essential, given that Māori have the poorest overall health status and are significantly disadvantaged in terms of health inequities. In preparatory material for Wai 2575, the Waitangi Tribunal's researcher notes that:

> In spite of greater Crown awareness of Māori health issues in more recent years, a number of Tribunals have also continued to note the continuing poor health outcomes for Māori into recent times and the persistent disparities between Māori and non-Māori, which the Tribunal *Ko Aotearoa Tenei* report described as a 'modern Māori health crisis'. The Tauranga Moana Tribunal also found that persistent disparity between Māori and non-Māori health outcomes 'indicates a failure of active protection by the Crown' and this failure was a breach of the principle of active protection'. (Crocker 2018).

The Ministry of Health has made explicit its commitment to honouring the Crown's special relationship with Māori under Te Tiriti o Waitangi. The Ministry's Statement of Strategic Expectations (Ministry of Health 2017a) outlines the Ministry's undertaking to actively meet its Te Tiriti o Waitangi obligations, including reducing health disparities for Māori. This commitment is also reflected in the Minister of Health's recent letter of expectations to DHBs (Clark 2018).

A system approach

Turning the tide in terms of health equity and meeting the Crown's obligations to Māori under Te Tiriti o Waitangi will require the health and disability system to create a significant cultural shift and effect fundamental system change. Specifically, it will require:

- focusing effort within current policy settings and service delivery on achieving equity

- undertaking continuous innovation and change, guided by a deeper understanding of equity gaps
- identifying where priorities for investment of time and resources lie, followed by increasingly directing action towards addressing inequities
- adopting a shared responsibility for equity.

While achieving equity for Māori, Pacific and low-income populations is a priority, addressing policy and service barriers that cause inequities will benefit a range of groups that suffer inequities in health outcomes. This includes specific groups in terms of ethnicity, gender identity, sexual orientation, age, geographic isolation, disability status and combinations of these various factors.

Discovery phase methods

Using evidence from a literature scan (Ministry of Health 2018d) data and analytics, and knowledge of the system, the Ministry created a draft framework for thinking about achieving equity (see Figure 3 on the next page for the updated framework). The framework included a draft definition of 'equity' in the context of the New Zealand health and disability system (see the next section). We used this framework as the basis of subsequent dialogue with a wide variety of people and groups to test thinking.

We decided to take a conversational approach to this discovery phase, rather than following a set process of large hui or formal advisory groups. Working with the CEO of Waitemata DHB in a co-sponsor relationship, we sought to understand the perspectives of different people within the system, and the challenges in different contexts, in an effort to find opportunities for improvement. This process included discussions with:

- Māori thought leaders
- Pacific thought leaders
- researchers in the health and disability sector
- our colleagues within the Ministry
- our colleagues across other health sector agencies
- our colleagues at the Treasury
- Māori and Pacific community providers
- various sector advocacy groups
- representatives of clinical groups.

We sought the opinions of these people and groups through a number of questions:

- Change for equity is occurring slowly in the health and disability system. What would it take to achieve health equity in a more timely manner?
- If we were to aim to achieve health equity within 20 years, particularly for Māori and Pacific people, what are the vital conditions in the health and disability system that need to be present now? How can we make a measurable impact in the next three to five years?

- With a view to achieving equity, where should we invest, to address gaps in our health policy, systems, services, research and knowledge about achieving equity?

Figure 3: Strategic framework for achieving equity in health and wellness

Mandate	It is a priority for the government to deliver equitable health outcomes for all New Zealanders			
Definition	In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes			
Te Tiriti o Waitangi	With **Te Tiriti** as the foundation, prioritisation for Māori is an imperative			A **Hauora Māori** competent workforce
Core principles	Tackling **wider social determinants** to influence and reshape the health system to be more equitable	The **inclusion of equity in definitions** of quality improvement and excellent performance	Enabling **people to become powerful agents of their own change**	A **competent workforce** that is connected to communities with health inequities
New Zealand health strategy alignment	A **people-centred** system not a practitioner-centred system	**Value and high performance** means striving for equitable health outcomes for groups that are disadvantaged so they experience a clear lift in health outcomes		Providing services **closer to home** includes having well-designed and **integrated pathways** for the journeys people take through our health system
Vision for the future	We will be successful when we have a system that delivers the same high-quality health outcomes and wellness for all people to reach their full potential no matter where they live, what they have or who they are			
Leadership	Achieving equity requires transformative leadership to partner and drive change at all levels of the system			
Greater coherence across the system	Understanding and responding to the complex health, cultural, economic, social and political conditions that affect health inequities requires cross-government, sector and community collaboration			
Shift in strategy – action and accountability	**Action:** A shift from a broad and imprecise approach to evidence-informed and coordinated effort, including defined priorities using a 'start small, think big, move fast approach'		**Accountability:** A shift from aspirational equity goals and 'soft leadership' to explicit ownership, leadership and accountability at all levels across the health system. Improved performance for priority populations will be demonstrated by targets, measures, monitoring and reporting of outcomes	
Approach – key themes	1 **Build understanding of equity problems** through smart data, analytics , research and rich insight that is multifaceted 2 **Work with sector partners to optimise system performance** making equity improvements transparent 3 **Foster innovation, trial and evaluate the responsiveness of services,** including through smart commissioning, resourcing, service design and partnerships 4 **Weave an equity focus into the operational landscape** through an integrated 'one plan, one team' 5 **Facilitate an equity focus across Government's strategic priorities** such as child wellbeing, mental wellbeing and primary health care			

A definition of equity

The Ministry set out to define 'equity' for the New Zealand health system context. We wanted the definition to be inclusive enough to incorporate all possible dimensions of equity (indigenous, socioeconomic, geographic, etc), while being grounded in a Māori world view; in the literature, especially Whitehead's seminal 1991 paper (Whitehead 1991); and in the international context, especially the work of the World Health Organization (WHO) (WHO 2019).[2] Many discussions started with testing the definition for its effectiveness in terms of creating a common understanding of 'equity'. Feedback was incorporated to arrive at a final version.

The Ministry's definition is as follows:

> In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

People involved in discussions liked the broad applicability of the definition, and its focus on health outcomes. They noted the links the definition has to the more detailed definition published by WHO (2019), and to definitions within the literature. They agreed with the concepts of unfair, unjust and avoidable, acknowledging that these concepts are reflected in legislation, social justice concepts, Te Tiriti and New Zealand's international obligations. These concepts set an expectation for government to address equity actively.

The second sentence generated the most discussion; with conversations about the choice of 'people' rather than 'populations', the use of 'advantage' rather than 'disadvantage' and the use of 'equitable health outcomes' rather than 'same health outcomes'. In terms of the choice between 'people' and 'populations', we note that there is a general understanding that measuring equity is dependent on defining populations and providing disaggregated information and comparisons. While acknowledging this, we ultimately decided that 'people' was a more inclusive term.

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[2] The WHO defines equity as follows:

'*Equity* is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. *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. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms.

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

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. 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.' (WHO 2019)

Our discussions about whether to use 'advantage' or 'disadvantage' in the definition focused on the Ministry's desire not to take a deficit approach to achieving equity. People we spoke with generally agreed that to achieve equity we need to take a rights-based approach, grounded in the Treaty and international conventions, rather than a disparities-based approach. While some people expressed concern that using the word 'advantage' could potentially normalise different levels of advantage, others noted that it was important not to use 'disadvantage,' which could be interpreted as a characterisation of people rather than the system disadvantaging people. A strong feeling was the need to recognise the impacts of history, colonisation, racism, discrimination and the social and economic determinants of health. The definition as it stands encompasses the important concept that people with different needs require different levels of resources. The concept of different levels of advantage captures the impacts of the broader social and economic determinants of health.

The Ministry agreed with the people who stressed that the goal needs to be achieving equitable outcomes, not just the same set of outcomes for everybody. At the same time, the Ministry acknowledges the need to move beyond a view of health outcomes alone to a concept of overall wellbeing with health as an important enabler of overall wellbeing.

For more information and discussion on the history of thinking about equity, both in New Zealand and internationally, see our report 'Achieving Equity in Health Outcomes: Highlights of important national and international papers' (Ministry of Health 2018d).

The Ministry formally adopted the definition of equity in February 2019; this is an important step towards achieving our aims. The health sector has started to use this definition. The Ministry has included it within its Operational Policy Framework, the set of business rules, policies and guideline principles that outline the operating functions of DHBs, for the 2019/20 year (Ministry of Health 2019).

Māori health and equity

Wai 2575 is the Waitangi Tribunal's Kaupapa Inquiry into Health Services and Outcomes, currently under way (Waitangi Tribunal, 2019b). Claimants in the first stage of the Kaupapa Inquiry focused on the Crown's failure to provide primary health care to Māori consistent with the principles of Te Tiriti o Waitangi. The claimants assert that primary health care is not sufficiently contributing to the achievement of health equity for Māori and as a result, Māori continue to experience significantly worse health outcomes than non-Māori.

'Equity is a priority for Māori and Treaty literacy is more of a dripping tap, rather than an everyday norm.'

Māori academics and thought leaders hui

The conversation in the Kaupapa Inquiry reflects a sense of urgency to address health inequities and advance Māori health aspirations within the Māori–Crown Treaty partnership (Ministry of Health 2018e). We noticed this sense of urgency in many of the discussions we had with stakeholders, along with calls to give Māori more say and more authority in organising their health services.

People the Ministry talked to expressed their sense of strong sector ownership of the goals contained in the Māori health strategy, He Korowai Oranga (Ministry of Health 2018f), but there is impatience with the speed and effectiveness at which the system is implementing those goals.

Typical recommendations for advancing Māori health aspirations included:

- greater Māori representation in decision-making
- greater recognition and promotion of Māori leaders, including within influential decision-making positions
- greater flexibility in governance, policy and service delivery arrangements, allowing more autonomy and ability to move at pace
- better and more regular reporting of trend data showing progress towards reducing differences in health equity for Māori
- tailored and holistic models of health and wellness that work for Māori.

Almost unanimously, stakeholder discussions, and not just within Māori groups, mentioned equity for Māori as the critical priority. Also almost unanimous was the view that no one solution will be effective in fixing long-standing inequities and persistent breaches of Treaty obligations. Māori identity, language and culture are essential ingredients in a system that works for Māori. Institutional racism was commonly mentioned as a root cause of the system's failure to work for Māori.

Stakeholders the Ministry talked with were philosophical about the deeply entrenched system challenges. Many wondered what could practically be done, given the inherent difficulty of changing an evolving and complex system. People expressed the desire for an incrementally radical and progressive change approach, under which resources and ownership is increasingly devolved to Māori and championed by everyone in the system.

Groups we spoke with that are prominent in the Wai 2575 Kaupapa Inquiry felt that part of their mandate is to hold the Ministry and Minister to account for equity failures for Māori. They are keen to see ongoing dialogue kept at a system level, and discussion focused on a critique of the big system levers.

Other stakeholders told the Ministry that DHB accountability and funding arrangements are not sufficiently focused on health equity for Māori, and that people and organisations have not been effectively held to account for failures to achieve equity for Māori. These stakeholders told us that DHB accountabilities and expectations arrangements need to improve, to create a significant shift in DHB performance for Māori. This could be achieved through improved understanding of the issues and coherent systems, standards and guidance that advance a Te Tiriti o Waitangi and equity agenda for Māori across DHBs.

A common theme was the need for an effective workforce strategy that creates a Māori workforce matched to need, and not just to population. Stakeholders talked about more effective infrastructure, with incentives to increase the cultural competency of the overall workforce, combined with an increased commitment to kaupapa Māori service provision.

A strong theme was the need to capitalise on opportunities for change from the ground up, by empowering iwi and Māori communities to develop solutions that work for them and make use of their knowledge. Such solutions are required not just in the health arena, but across the social and economic spectrum. Implementing them will involve acknowledging and addressing both historic determinants of inequity and contemporary issues, such as the impact of racism. Tackling the social determinants of health and interrupting inequities for Māori, stakeholders considered, would require a commitment to collaborative, constructive action across the health, education, housing, social and income sectors, jointly owned by the respective agencies and Māori themselves. They considered that this was the case for Māori more so than for any other group, taking into account both historical and contemporary Treaty breaches. Making real improvements to wellbeing is a particular priority for the Government, and the wellbeing of Māori is a focus of Budget 2019.

The Māori stakeholders the Ministry spoke to demonstrated a healthy balance of optimism and caution, and voiced an acknowledgement that a long-term investment in creating public value is required. Some mentioned the potential for public backlash around 'affirmative treatment' and called for non-Māori leaders (such as chief scientists, business leaders etc) to write, report and publicly comment on the costs of inequity and the impact of unfairness. Overall, we found that people have the heart for change but are pragmatic about what can meaningfully be accomplished, given the long-standing historical and system issues, diverse views and changing contexts that make up the background against which achieving health equity for Māori sits.

Overarching system issues

The aim to achieve health equity for Māori and meet Te Tiriti o Waitangi obligations sits within a broader context. To effect meaningful change, a common understanding of the big system issues is needed, and of what it will take to address them.

Stakeholders regularly identified changes to big system levers and leadership commensurate with the challenge as a core priority.

People raised the need for a commonly understood rights-based approach, based on Te Tiriti o Waitangi, United Nations declarations and the existing legislation. They called for a clear understanding of why things are the way they are. Some mentioned the need to address particular issues, such as the intergenerational impact of embedded racism on social outcomes, and the need to foster an understanding of the effects of cumulative overlapping disadvantage.

In tackling inequity, people stressed the importance of including all aspects of the health and disability system, as well as understanding how current structures exacerbate inequities. Access barriers, quality issues, staff training and competency issues, the inequitable distribution of effort and resources, and a limited focus on holistic wellness within a culturally adaptive framework create obstacles to achieving equity.

Most stakeholders expressed concern that the strategies that currently guide and shape the sector, and the current core funding mechanisms, often have holes where equity is concerned. These holes include a poor understanding of unmet need, fragmented funding, siloed organisations and perverse incentives in contracting. In addition, some felt that current monitoring and evaluation frameworks do not meaningfully recognise or incentivise changes to achieve equity.

To move forward, groups we spoke with expressed a need to more effectively facilitate Māori access to services that work for them, and Māori involvement or leadership in developing and operating those services. This is critical to improving Māori health outcomes.

Figure 4 on page 13 presents a view of the health and disability system. We present it here to provide an outline of the complex nature of the health and disability system.

Social and economic determinants

Addressing the social and economic determinants of health and wellbeing was recognised as an essential factor in achieving equity overall; in fact, such determinants have a greater impact on people's overall health than health and disability services do (Ministry of Health 2018g). Health and wellness and the various social and economic determinants are linked in complex ways. There is general agreement that a broad, whānau-centred/people-centred approach is an effective way to tackle these complex interdependencies.

'Health is the indicator for the other social determinants; health needs to push the other areas.'

Meeting with Dr Camara Jones, past President of the American Public Health Association

People the Ministry spoke with desired a whole-of-government approach to addressing inequities in health outcomes; for example, involving simultaneous work in the areas of housing, educational disparities and the reduction of child poverty. There is opportunity for the health sector to take a greater leadership and advocacy role in addressing inequities across the board, alongside other agencies, including central and local government. Cross-agency work programmes and the Treasury's Living Standards Framework (The Treasury 2018) are significant enablers in this regard. In its own work on achieving equity, it will be important for the Ministry of Health to work closely with the Treasury and other agencies to influence the Living Standards Framework and adapt and apply it for health contexts.

Figure 4: The New Zealand health and disability system
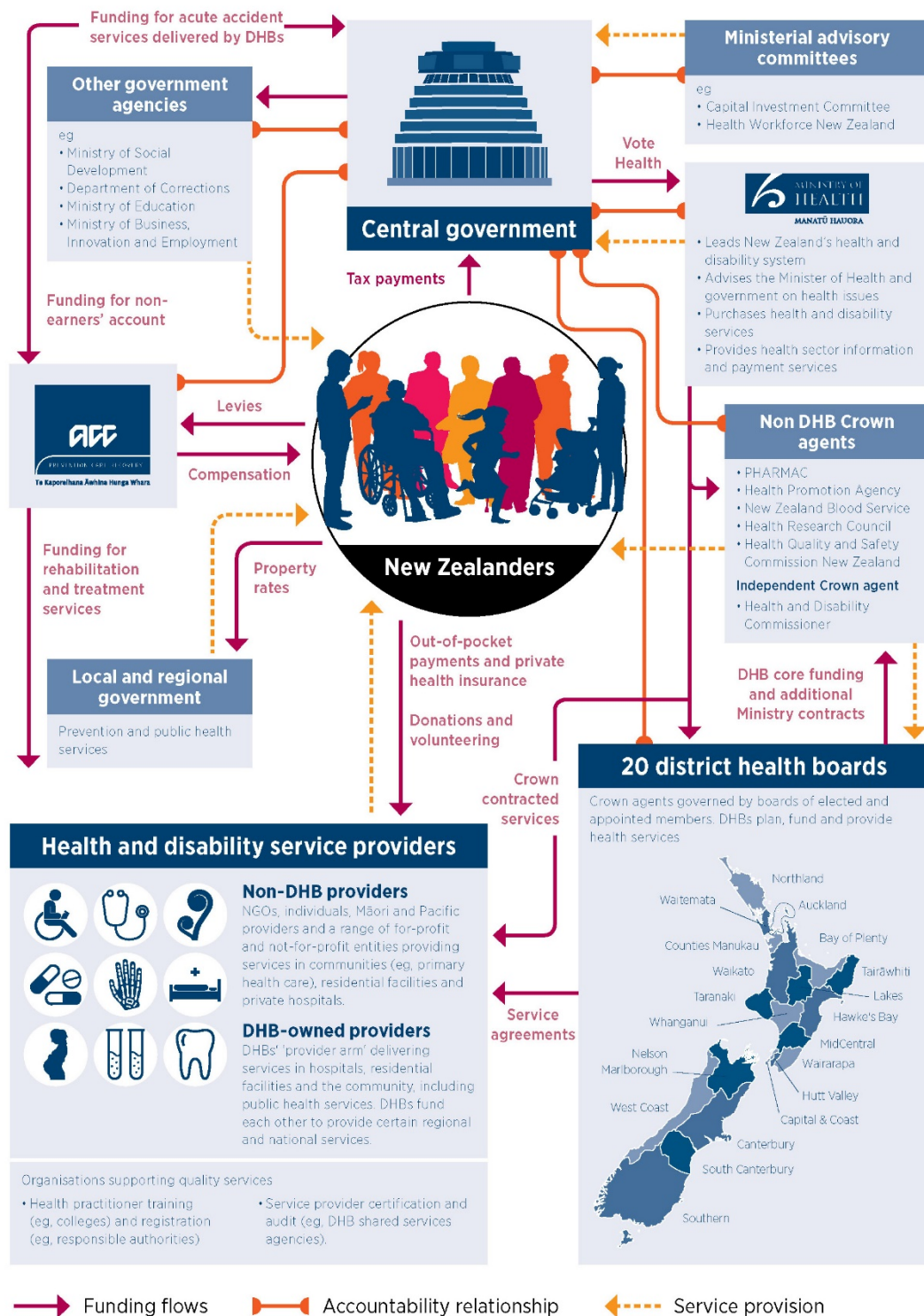
Source: Ministry of Health 2017b, with a correction adding the missing accountability relationship between central government and District Health Boards (DHBs).

A strategy for achieving equity

In the Ministry's dialogue with stakeholders, we asked them to consider the next steps, so that the Ministry could start to form an idea about what an overall approach for achieving equity might look like.

People the Ministry talked to acknowledged the significant amount of knowledge and evidence on achieving equity that already exists, in the form of research and epidemiology. They also acknowledged the strategic direction set out in He Korowai Oranga: the Māori Health Strategy (Ministry of Health 2018f), 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing (Ministry of Health 2014), the New Zealand Health Strategy (Ministry of Health 2016) and the New Zealand Disability Strategy (Office for Disability Issues 2016). Furthermore, we note that there is work occurring across government to address long-standing issues to do with the social and economic determinants of health. For example, the Social Wellbeing Committee is made up of public service chief executives, and focuses on the Government's child and youth wellbeing strategy (Department of the Prime Minister and Cabinet 2019).

There is a strong desire to supplement current knowledge with more disaggregated and nuanced information on groups who have poorer health outcomes. People expressed a need for fresh insights about the lived experiences of vulnerable and disadvantaged groups, including a greater understanding of their world views.

Important strategic challenges include:

- advancing the aspirations of iwi and Māori, based on unique Treaty obligations, while meeting the equity needs of the Māori population and other population groups who experience significant inequitable health outcomes (such as Pacific peoples)
- creating a space to meaningfully address racism and discrimination in all its forms
- creating responsive organisations that meet minimum standards for being focused on equity; for example, by ensuring that equity considerations and Treaty obligations are first principles in policy analysis and decision-making
- ensuring that leaders and managers take responsibility for addressing equity; for example by articulating expectations and implementing standards
- ensuring that decision-making takes place as close to communities as possible, and that no group (however defined) is left behind
- ensuring that actions taken to address inequities are timely, effective, pragmatic and based on robust evidence and change methodologies (stakeholders mentioned the concepts of change science, dissonance and incremental radicalism)
- increasing responsible reporting of improvement over time, with the right mix of incentives and sanctions
- making better use of data and analytics to predict outcomes and intervene early, to better target resources

- developing approaches that foster collective and collaborative responsibility to meaningfully tackle the social and economic determinants of health.

To achieve an overall strategy for achieving equity, leadership needs to be present and effective, from the top of the system and all the way through it. People said that, in terms of equity, effective leaders should:

> 'Good leaders don't stay in their offices, they get on the floor, stay connected to their communities.'
>
> *Pacific health provider*

- have a clear vision for equity
- create meaningful partnerships, including with community leaders and providers
- manage the risks of the perception of special treatment, and champion explicit messages concerning fairness and the use of particular resources and approaches
- ensure action is meaningful and aligned with other agencies, and not tokenism.

Some people noted that the Ministry had a key stewardship role in terms of ensuring effective leadership for equity.

The Health and Disability System Review has a focus on creating a system that is equity geared, rather than just committed to addressing inequities (Health and Disability System Review, 2019). This is an essential foundation for building the appropriate structural architecture for the system.

An open programme approach

In general, people the Ministry spoke to widely supported an active, flexible and open programme approach to achieving equity. The term 'open programme' means not being rigid, slow to act or tied to narrow terms of reference. The challenge in achieving equity is in enabling shared ownership and leadership that allows work to be dynamic and move at pace across sectoral, organisational and professional boundaries. This is to ensure that everyone in the system is both acting in their direct sphere of influence and galvanising change across the board. Equity must become everyone's business.

The Ministry's recently established Outcomes and Equity Committee (Ministry of Health 2018c) is prioritising the achievement of long-term gains in the complex health environment. Its challenge is to enable potentially disruptive change and reprioritisation while maintaining people's trust, supported by meaningful evaluation and insights.

Partnerships

People we spoke to noted that meaningful relationships would be a critical enabler in achieving equity; particularly partnerships and relationships with iwi and Māori. Discussion on partnerships and relationships focused on the need for relational trust with stakeholders and communities, across the health and disability system and outwards to areas that impact health. Challenges achieving such relationships include:

- intergenerational mistrust due to past experiences, particularly among the most disadvantaged groups
- a general willingness to do something different, but a perceived lack of permission to do things differently
- an uncertainty within some providers that serve Māori and Pacific communities about who to engage with 'in the system', and how to engage.

Communications

People the Ministry spoke to expressed a desire for communications concerning equity to be tailored to the communities they targeted, and for messages directed towards the public at large to be carefully considered, particularly to address risks of a backlash. Communication tools will need to be used effectively, to avoid misrepresentation and to create a common story of how we collectively are making progress, in a narrative that highlights public value.

As a first step in terms of communications, the Ministry has been disseminating our definition of 'equity' (see Introduction above), and explaining why the 'equity lens' is so important. It is also working on the development of videos and other resources that succinctly communicate the concept of health equity.

We are working to create an equity narrative that recognises that different audiences and contexts will require different information. Key messages on equity will foster dialogue, inform, educate and exemplify equity in action. Digital platforms also offer an opportunity to connect people, and to deliver messages in innovative ways.

Pacific health and equity

'Ala Mo'ui: Pathways to Pacific Health and Wellbeing (Ministry of Health 2014) articulates the Ministry's priorities in terms of achieving equity for Pacific peoples. The strategic action plan has the backing of the Pacific community. The Ministry is currently developing a refreshed set of aims in its strategic action plan.

To fully achieve health equity for Pacific peoples, stakeholders desired:

- better understanding of the different and changing needs and intersectionality of diverse Pacific populations
- better data and analytics, to understand the aggregates of Pacific communities that mask inequities
- coordinated and well-resourced action, informed by 'Ala Mo'ui, based on meaningful partnerships with Pacific leaders and involving diverse communities
- a culturally competent workforce, and strengthened Pacific workforce in particular
- the design of policy, service delivery and measures of success that reflect Pacific epistemologies
- the opportunity to make the most of the knowledge and ideas of recognised Pacific leaders.

People we talked to noted that, in this context, we need to scale up and invest in innovation, particularly where Pacific initiatives are showing promising gains in reducing differences in health for Pacific communities. Some expressed a concern that the Government was generally reactive to Pacific equity issues, rather than proactive.

> 'The increasing diversity of Pacific populations means we need to be forecasting to understand Pacific needs.'
>
> *Pacific academics and thought leaders fono*

Accountability and monitoring

Accountability and monitoring levers within the health and disability system are key to achieving equity. Stakeholders argued strongly for every part of the health and disability system to be accountable for achieving equity. A common theme of the discussions we undertook in this discovery phase was that equity needs to be embedded in all aspects of the system's accountability framework, from long-term strategic planning to short-term key performance indicators.

In addition, people felt a focused and collective approach to equity across government is needed, to address the most challenging issues, and those that are beyond the remit of any individual agency. People talked about an accountability and monitoring approach that is people-centred, integrated and enduring.

People expressed a strong desire for a range of long-term measures that address equity with a clear idea of what 'good' is. These measures would be supported by ensuring that we apply an equity lens and a strong performance story outlining progress to all targets and measures within the health system. The Ministry is currently working on a measurement framework that incorporates these factors. This process is informed by literature that identifies good practice measurement to improve equity.

In discussions, people acknowledged the impact targets can have on system behaviour, but noted that they could also have perverse incentives. People generally preferred the idea of a broader improvement focus entailing leadership accountability and effective governance, rather than hard measures. Some held up the System Level Measures (SLM) programme as good practice (Ministry of Health 2018h). For health measurements to have a positive effect on equity, the system will need to reward providers for doing meaningful work to improve health equity, and support those that are struggling, particularly if they are serving disadvantaged populations.

> 'Everyone must be accountable for coming up to speed.'
>
> *Māori academics and thought leaders Hui*

A strong overall theme, also evidenced in the Wai 2575 Kaupapa Inquiry, is that inaction to meaningfully reduce inequities, particularly for Māori, is not acceptable. In making this point, people referred to the Ministry, as steward of the system and to DHBs as providers and commissioners of services. They noted that currently, there are no real sanctions for failing to achieve equity.

Commissioning of services

Unsurprisingly, the topic of commissioning of services generated considerable discussion in the engagement process we undertook.

People/whānau-centred services

People expressed a strong belief that services should be focused on and meet the needs of the diverse groups of people they are there to serve. To achieve our aims in terms of health equity, it is essential that we create services in partnership with the people and communities that are currently marginalised or missing out altogether. People noted that Māori, in particular, wanted to have a greater role in service commissioning.

Components of people/whānau-centred services include:

- recognising different world views
- holistic service models and locations that are easy for people to access
- service times that fit with people's lives
- recognition of people's lived experience, and the ecosystems in which people live, work and belong.

> 'Provide end-to-end services to make it easier for clients to access and benefit from health services.'
>
> *Māori health provider*

These factors are significant contributors to people's health status, and their ability to achieve wellness. There was a call for a much stronger focus on wellness in community-based health care, and the resources necessary to achieve that, rather than sickness in hospital-based settings.

Incentive structures in the current commissioning system

People felt that the incentive structures embedded in the current commissioning system include funding formulas that reward existing service patterns, are biased towards a Western medical world view and do not recognise unmet need. In addition, people found fault with the short-term, single-issue contracting that characterises the current system, and its low-trust, high-compliance, frequent-audit approach to contract management. They considered that the system is not geared up to support innovation aimed at reducing inequities at a systemic level, or to evolve to equalise outcomes for high-needs communities. In addition, there are limited sanctions for not meeting

unmet need, or incentives to find out where unmet need may lie. Māori health providers reported having to compete with DHBs' provider arms for funds and attention from DHBs.

To achieve equity, an authorising environment that incentivises a long-term, evidence-informed view of the whole patient journey is needed, and the sector must provide 'whole-of-life' care adapted to local needs. In addition, the commissioning system needs to take a broader view, beyond just health. People we spoke to widely supported the holistic view of the Whānau Ora approach (Te Puni Kōkiri 2019), and saw it as an example of how we can direct resources towards wellbeing in the context of addressing the wider social and economic determinants of health.

Organisation of commissioning

The stepped mental health service models that work for Māori and Pacific youth need to be upscaled and sustainable.'

Pacific health and wellbeing provider

In discussing how we could reorganise commissioning across the system, and some of the challenges we face in this regard, the overall preference of the people the Ministry spoke to was for greater integration of service delivery across the system, and commissioning to support that. This was not necessarily a 'single provider providing all services' style of integration, people stressed. Instead, the focus would be on making the journey as seamless as possible within organisations, across organisations and professional boundaries, while still respecting professional roles and accountabilities.

People's desire was for the commissioning effort to be on where it can make the most impact in terms of increased wellness and reduced morbidity. To achieve this, the system will need to be resourced to a level at which it can identify and make the most of relevant opportunities providing holistic models of care, in partnership with the communities concerned.

People we spoke to also expressed the view that, in the current system, permissive and safe conditions within which to innovate are lacking. People noted the Healthy Families NZ initiative as an example of innovation and equity in action in Māori and Pacific communities (see **www.healthyfamilies.govt.nz**). People raised the pressure that efficiency brought about through standardisation can have on restricting innovation and creativity as a challenge, along with the confusing 'clutter' of providers and services that current fragmented commissioning practices create.

Data, analytics and insights

Data, analytics and insights are critical tools in achieving equity in health outcomes. They have an essential role in supporting research into actions that can potentially address inequities and the evaluation of new and existing programmes and services.

> 'We need to combine analytics with the lived experiences of services users, to design interventions that will make a difference.'
>
> *Māori and pacific nurses hui*

In terms of data, the focus needs to be on building datasets that contain multidimensional and granular information. An ability to disaggregate along population group lines is critical. For example, data needs to be able to shed light on dimensions including:

- iwi classifications
- people's disability status
- people's location
- social and economic deprivation
- consistent ethnicity classification data protocols.

People called for more routine publication of outcomes, behavioural risk factors and quality-of-life data, as well as the current administrative data sets. They also mentioned the need to link data across the broader government sector, to foster an understanding of the impact of the different determinants of health and wellbeing; this is possible through Statistics New Zealand's Integrated Data Infrastructure (StatsNZ 2019). One key enabler for good analytics on equity is a set of complete, accessible and relevant population data, especially at the sub-DHB level, and for the purpose of more granular ethnicity breakdowns.

In terms of analytics, considerations that people thought were relevant included:

- the importance of reporting trends over time
- the ability to look at data from a patient journey perspective
- access to insightful information about whānau from across systems, sectors and agencies.

Furthermore, analytics output needs to be accessible to partners and stakeholders, and presented in a way that non-technical people can make use of, where possible, while adhering to privacy and security expectations. Some noted that current expertise to interpret data and create meaningful stories from it is limited; we need to grow this expertise across the health and disability system.

The areas of evaluation and consumer insight are viewed as an essential step beyond analytics. Combining evidence and analytics with our knowledge of the lived experiences of service users, whānau and their communities will inform the design of interventions that work for those who currently do not trust or use health services.

Some promising work in this area has already begun; for example, in the area of addressing smoking among young Māori women (Wehipeihana et al 2018).

An essential aspect of designing interventions is an understanding of the downstream costs of inequities, and our inaction in addressing them. To achieve equity, there needs to be an understanding of where upstream investments for sustainable change can be made: invariably, this will be for the purpose of prevention or early intervention, and often early in the life course. In some areas this will mean, measuring aspects that are not currently measured, to determine the true cost of meeting and not meeting unmet need.

Community capacity-building

'A culturally diverse and competent workforce will require the sector capacity to build it.'

Pacific academics and thought leaders fono

Most of the discussion on community capacity-building happened within the context of Pacific and Māori health, given the disproportionate burden of health inequity these populations experience. People expressed a desire to align the efforts of DHBs, primary care services and the community, and to bring the approach the Ministry take to supporting and improving Pacific and Māori health providers to maturity.

Pacific and Māori providers want to be meaningfully involved in defining 'quality' for their populations. Some people noted that the Ministry and DHBs need to broaden their engagement approaches with Pacific communities using multiple channels; there is currently a tendency to over-rely on engagement through churches. People noted that Pacific communities have evolved; so have other channels for engagement. See 'Yavu – Foundations of Pacific Engagement' (Ministry for Pacific Peoples 2018) for more information.

An interesting aspect that came up in the discussions was the concept of the whānau and broader community as a 'volunteer' workforce, supporting the wellbeing of their own and other individuals interacting with the health and disability system. Important principles people mentioned included treating the whole whānau, not just the individual, and health workers connecting meaningfully with whānau, to keep family members well in the context of strong whānau and communities.

People the Ministry spoke to recognised the following enabling conditions for community capacity-building among Māori and Pacific communities:

- flexible funding, to enable providers to design services to meet the needs and aspirations of their community
- recognition of providers as part of their own communities, and therefore invested in their communities
- service specifications and resources that recognise and fund for the magnitude of inequities, disadvantage and size of difficulty, based on population configuration
- results-based accountability contract arrangements (Ministry of Health, 2018i) on at least three-year cycles
- a shift in relationships and contractual arrangements, from a compliance-driven commissioning and monitoring culture to a relational, learning and improvement culture
- a fair playing field, on which Māori and Pacific providers have more certainty about sustainable funding from DHBs.

People noted that the most significant change will and does already happen at the coalface.

Workforce

In terms of equity, a sector workforce matched to need, rather than just to population proportions, remains an important aim. Given the inequitable outcomes Māori and Pacific populations currently experience, this means a health workforce in which the proportions of Māori and Pacific workers are well above the population proportions of these groups, across all levels of the workforce.

'Grow and support greater Maori numbers in the health workforce and infrastructure to ensure they get qualified.'

Māori workforce development organisation

The responsiveness of the workforce was another common theme in our discussions. People noted that the workforce needs to be genuinely culturally responsive, and not just culturally competent or safe. It also needs to be responsive to people with disabilities and others with diverse needs.

People acknowledged that the processes for growing tomorrow's workforce, and for enhancing the current workforce, are complex. These processes include protecting and expanding scholarship programmes so that they increase the capacity of the Māori and Pacific workforces, and ensuring that we mandate, construct and adequately resource mechanisms for improving cultural responsiveness. Giving priority to culturally responsive practices for and with Māori (Hauora Māori competencies) across the workforce and support for the provision of kaupapa Māori service models were common themes.

To create a workforce that effectively works towards health equity, the sector will need to improve its understanding of the make-up of the workforce and its distribution across the system; to this end, we will also require insightful data.

Next steps

The report has highlighted the fact that tangible improvements in health equity will require concerted and collaborative effort, in the day-to-day work of the entire health system and across government.

The Ministry of Health is taking practical steps, and the time to create understanding of what equity means, particularly in the context of meeting our Te Tiriti o Waitangi obligations to Māori, and of how we can achieve equity.

Important considerations this first phase has highlighted include the need for:

- targeted resources to address health equity for Māori consistent with Te Tiriti o Waitangi obligations
- discussions, systems and processes across institutions to address all forms of racism and discrimination
- clear leadership and management responsibilities for embedding an equity focus into day-to-day business and reporting on progress
- thoughtful engagement with those expected to deliver on equity priorities, and adequate resourcing, data and analytics
- prioritising the most evidence-informed and innovative initiatives for improving equity
- alignment of business planning, human resources, financial management, performance measurement and accountability mechanisms to address equity.

There is opportunity for the health and disability system and the broader public sector to better coordinate effort, including through strengthening the understanding of and commitment to reducing inequities, and through implementing and sharing practices that are effective in improving health as an enabler of wellbeing.

Finally, it will be important that all stakeholders involved in the delivery of health services work in ways that are responsive to people, whānau and communities who are impacted by inequitable treatment. In this way, we can ensure that the experiences and knowledge they hold contribute to improving the health services they receive.

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