

Te Whatu Ora
Health New Zealand

Health Equity in Aotearoa New Zealand

An example of addressing the life expectancy gap

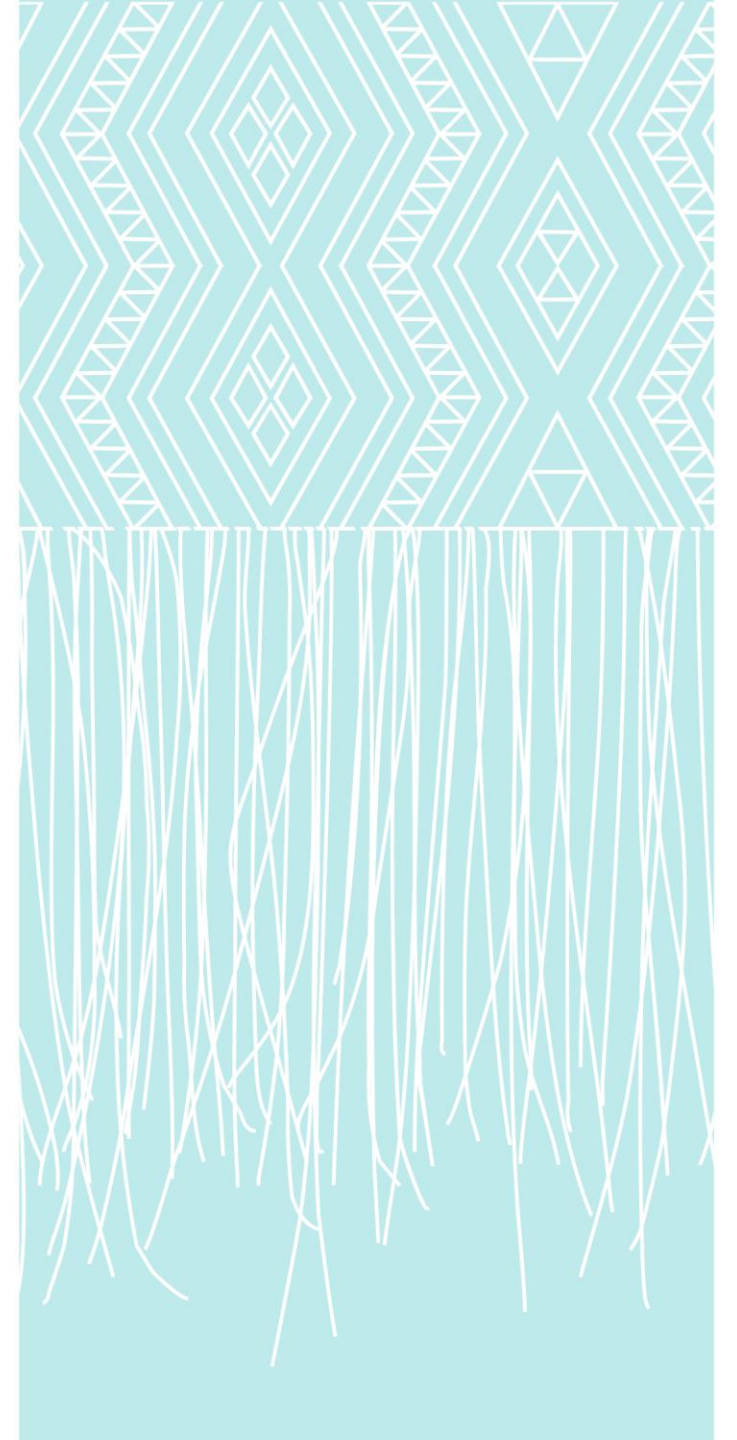
Dr Karen Bartholomew
Director Health Equity, Service Improvement & Innovation
31 October 2023

Positionality

- I am a Pākehā (white) public health physician with screening, research, ethics and operational management experience
 - Influenced by my own interpretive frameworks and experience
 - Social justice and equity are at the heart of a public health approach, public health and equity work is deeply political
- Invited in to develop work programme (Māori Health Pipeline) particularly focused on prevention/screening
 - Māori determined what these were and how they evolved
 - Māori leadership, governance, monitoring, and staff are critical
- Personal commitment to anti-racism, concrete action, continual reflection, always learning and seeking to improve

Overview

1. Health reforms in Aotearoa New Zealand
2. Life expectancy and the ethnic-specific life expectancy gap
3. The Māori Health Pipeline programme
4. Lessons learned

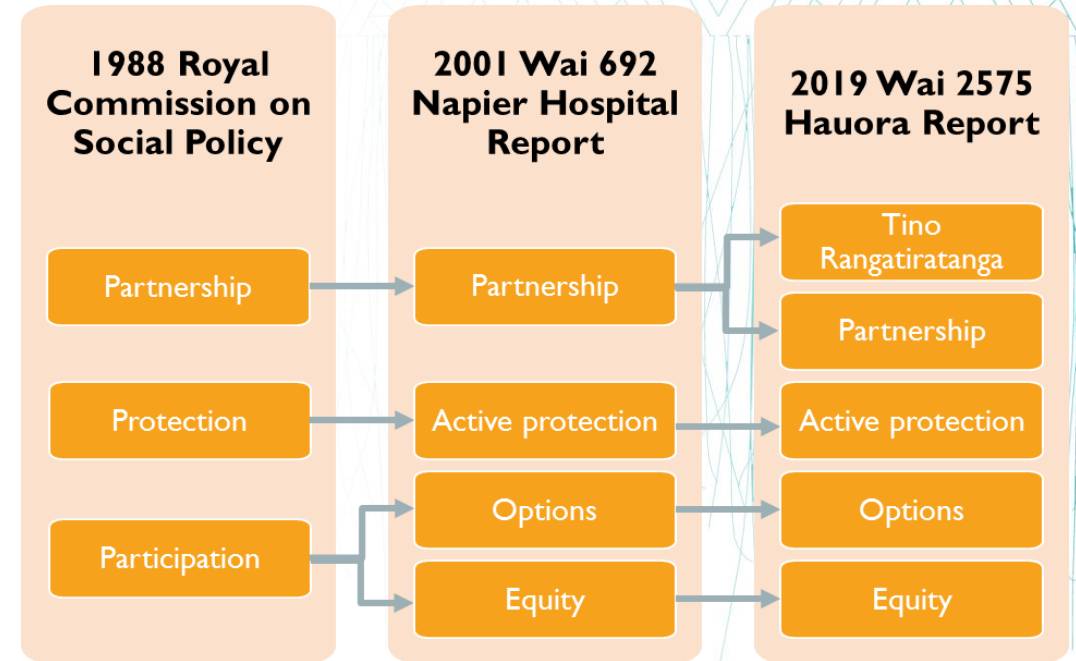


1. Health reforms in Aotearoa New Zealand



Driver of the reforms

- Waitangi Tribunal Wai2575 Claim report (Hauora Inquiry 2019) – focus initially on primary care
 - Clearest theme was the **failure** between policy/articulation of Te Tiriti o Waitangi with the intention to address Māori health inequity and implementation/execution
 - Statutory obligations under Te Tiriti and the legislation not met, and lack of accountability
- 2019–2020 Health and Disability Systems Review (*the Simpson Report*)



<https://waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry>

NZ has had a very active health reform landscape

- 1938 Social Security Act – Dual public and private system (primary care private with public subsidisation, small private insurance and provision)
- 1974 – No fault compensation – Accident Compensation Corporation (ACC)
- 1983 – 14 Area Health Boards – population based funding
- 1993 – 4 Regional Health Authorities, with 23 Crown Health Enterprises (CHEs, for-profit), Public Health Commission and PHARMAC established (medicines buying agency)
- 1998 Single national authority – Health Funding Authority (HFA), with 24 Hospital and Health Services (HHS, not-for-profit)
- 2001 – 21 District Health Boards (DHBs), boards with locally elected members
- 2002 – Primary Health Organisations (non-geographic based)
- 2019 – Wai2575 Hauora Report and the Health & Disability Review
- 2022 – Single national authority – **Te Whatu Ora** (Health New Zealand) with **Te Aka Whai Ora** (Māori Health Authority) established as a separate agency

The first two of the three Purposes of the Act is:

1. design, arrange, and deliver services to achieve the purpose of this Act in accordance with the health sector **principles**
2. **achieve equity** in health outcomes among New Zealand's population groups, including by striving to eliminate health disparities, in particular for **Māori**

Section 1 (1) **Principles:**

(a) the health sector should be **equitable**, which includes ensuring Māori and other population groups—

- (i) have **access** to services in proportion to their **health needs**; and
- (ii) receive **equitable levels of service**; and
- (iii) achieve **equitable** health **outcomes**:

(b) the health sector should **engage with Māori, other population groups, and other people** to **develop and deliver** services and programmes that **reflect their needs and aspirations**, for example, by engaging with Māori to develop, deliver, and monitor services and programmes designed to improve hauora Māori outcomes.

(c) the health sector should provide opportunities for **Māori to exercise decision-making authority on matters of importance to Māori** and for that purpose, have regard to both—

- (i) the strength or nature of Māori interests in a matter; and
- (ii) the interests of other health consumers and the Crown in the matter.

- (d) the health sector should provide **choice of quality services to Māori** and other population groups, including by—
- (i) **resourcing services to meet the needs and aspirations** of iwi, hapū, and whānau, and Māori (for example, **kaupapa Māori** and whānau-centred services); and
 - (ii) providing services that are **culturally safe and culturally responsive to people’s needs**; and
 - (iii) developing and maintaining a **health workforce that is representative** of the community it serves; and
 - (iv) harnessing clinical leadership, innovation, technology, and lived experience to continuously improve services, access to services, and health outcomes; and
 - (v) providing **services that are tailored** to a person’s mental and physical needs and their circumstances and preferences; and
 - (vi) providing services that **reflect mātauranga Māori**.
- (e) the health sector should protect and promote people’s health and wellbeing, including by—
- (i) adopting population health approaches that prevent, reduce, or delay the onset of health needs;
 - (ii) undertaking **promotional and preventative** measures to **protect and improve Māori health and wellbeing**; and
 - (iii) working to improve mental and physical health and diagnose and treat mental and physical health problems **equitably**; and
 - (iv) **collaborating with agencies** and organisations to address the **wider determinants of health**; and
 - (v) undertaking **promotional and preventative measures** to address the **wider determinants of health**, including climate change, that adversely affect people’s health.

Objectives of Te Aka Whai Ora (Māori Health Authority)

Objectives specifically for Te Aka Whai Ora set out in the Act are:

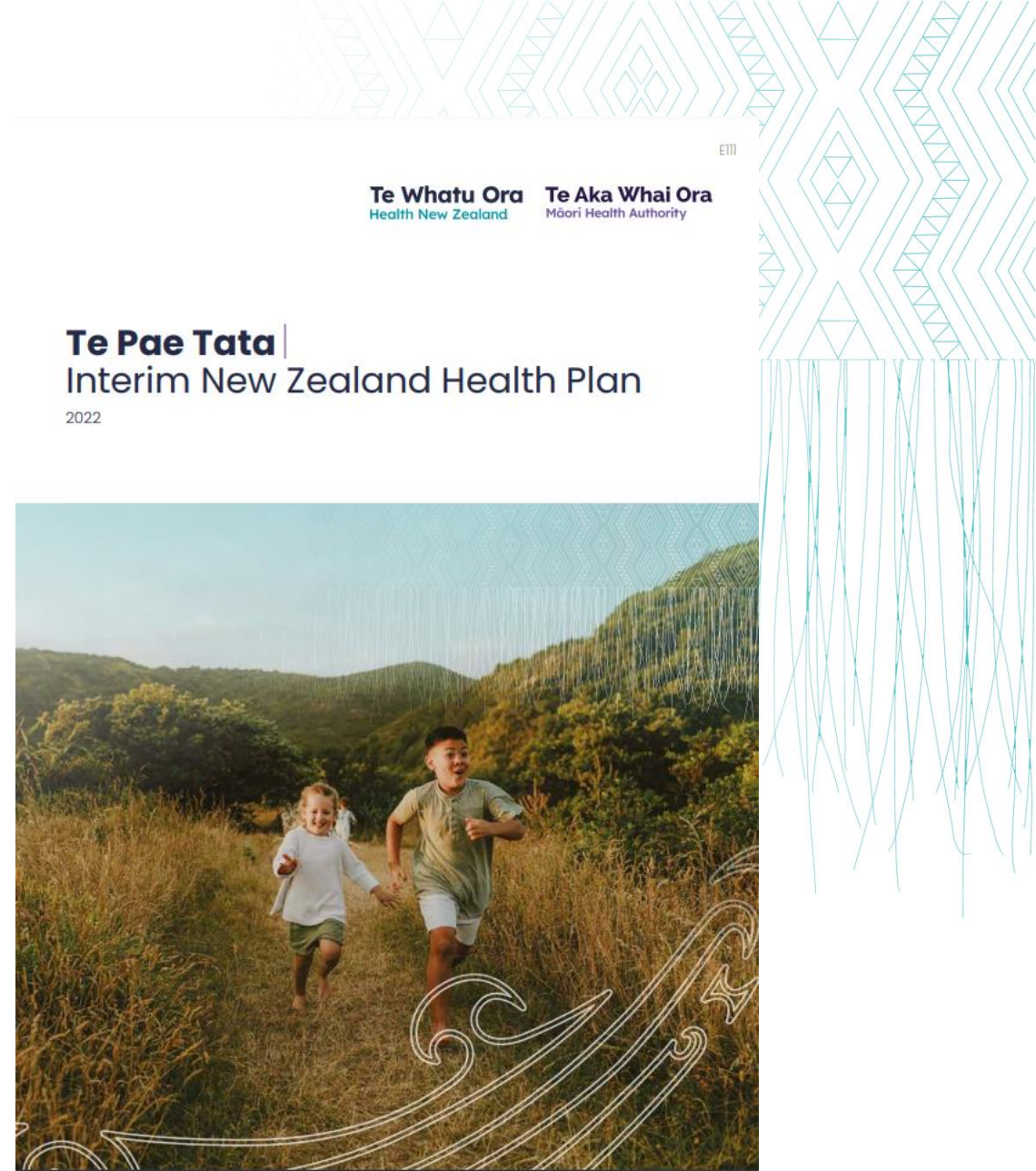
- (a) ensure that planning and service delivery respond to the **aspirations** and needs of whānau, hapū, iwi, and Māori in general; and
- (b) design, deliver, and arrange services
 - i) to achieve the purpose of this Act in accordance with the health sector principles; and
 - ii) to achieve the **best possible health outcomes** for whānau, hapū, iwi, and Māori in general; and
- (c) promote Māori health and prevent, reduce, and delay the onset of ill health for Māori, including by collaborating with other agencies, organisations, and individuals to address the **determinants of Māori health**.

Many functions including: policy, planning, commissioning, monitoring, designing and delivering services, and the establishment of **Iwi-Māori Partnership Boards** (IMPBs)

Te Pae Tata (Interim Health Plan) and the national strategies

Summary of priorities in Te Pae Tata

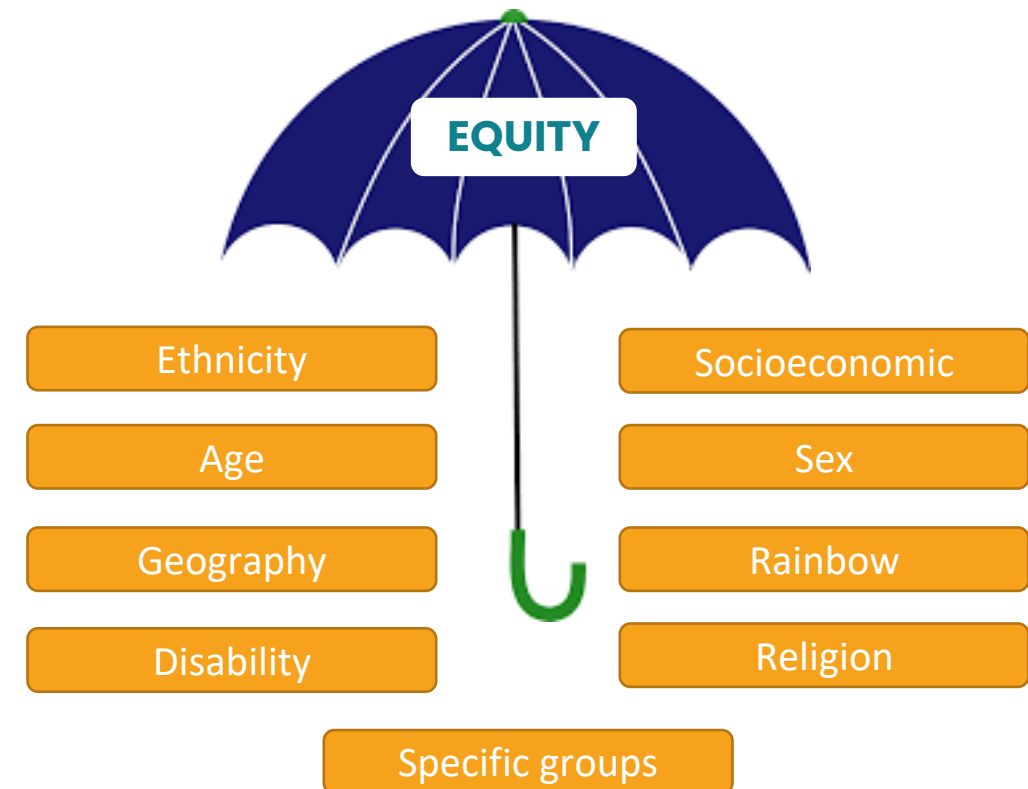
- Pae ora | Better health and wellbeing in our communities ✓
- Kahu Taurima | Maternity and early years ✓
- Mate pukupuku | People with cancer ✓
- Māuiuitanga taumaha | People living with chronic health conditions ✓
- Oranga hinengaro | People living with mental distress, illness and addictions ✓
- Māori health ✓
- Pacific health ✓
- Tāngata whaikaha | disabled people ✓



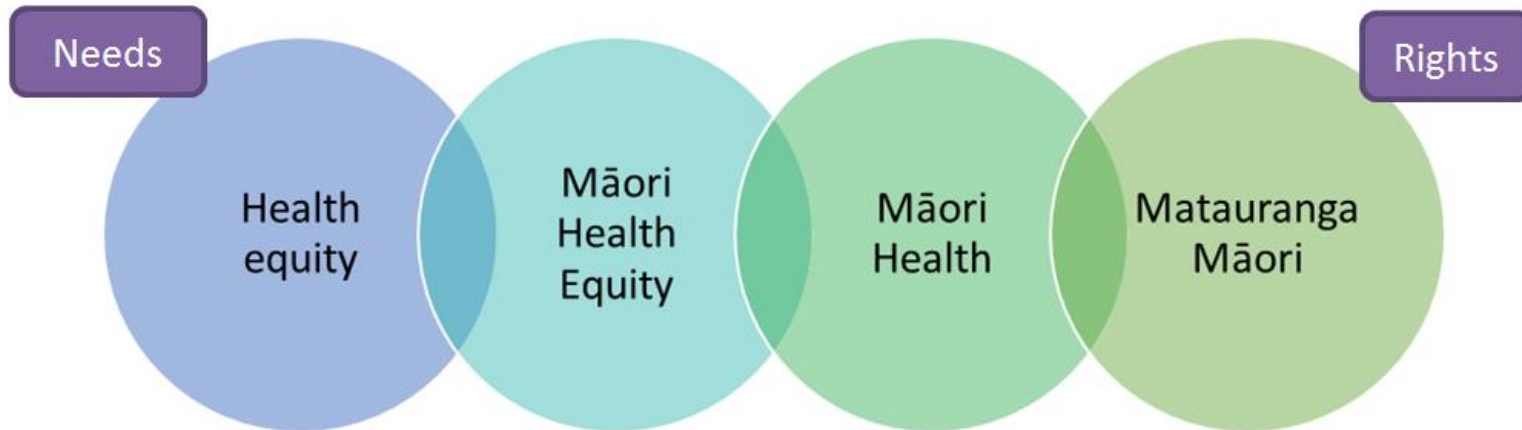
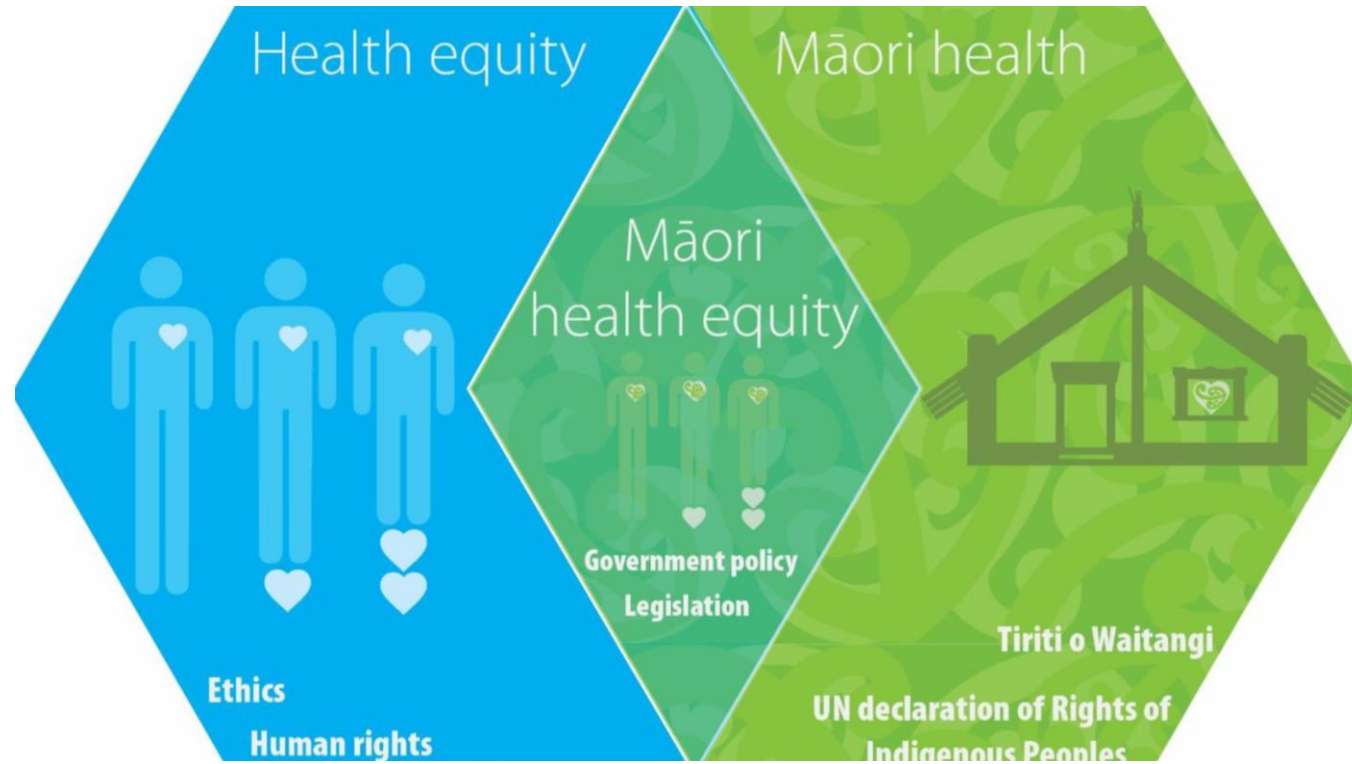
- Range of equity parameters
- Pervasive and ongoing ethnic-specific inequities in health access, quality of care and outcomes across a range of indicators
- Inequities are often intersectional, however there are inequities by ethnicity when other inequities are 'accounted for'
- Māori (Indigenous people) have the right to health under:
 - Te Tiriti o Waitangi
 - The United Nations Declaration on the Rights of Indigenous People (UNDRIP)
 - Legislation (Pae Ora (Healthy Futures) Act)

Equity Definition:

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. *Ministry of Health (2019)*



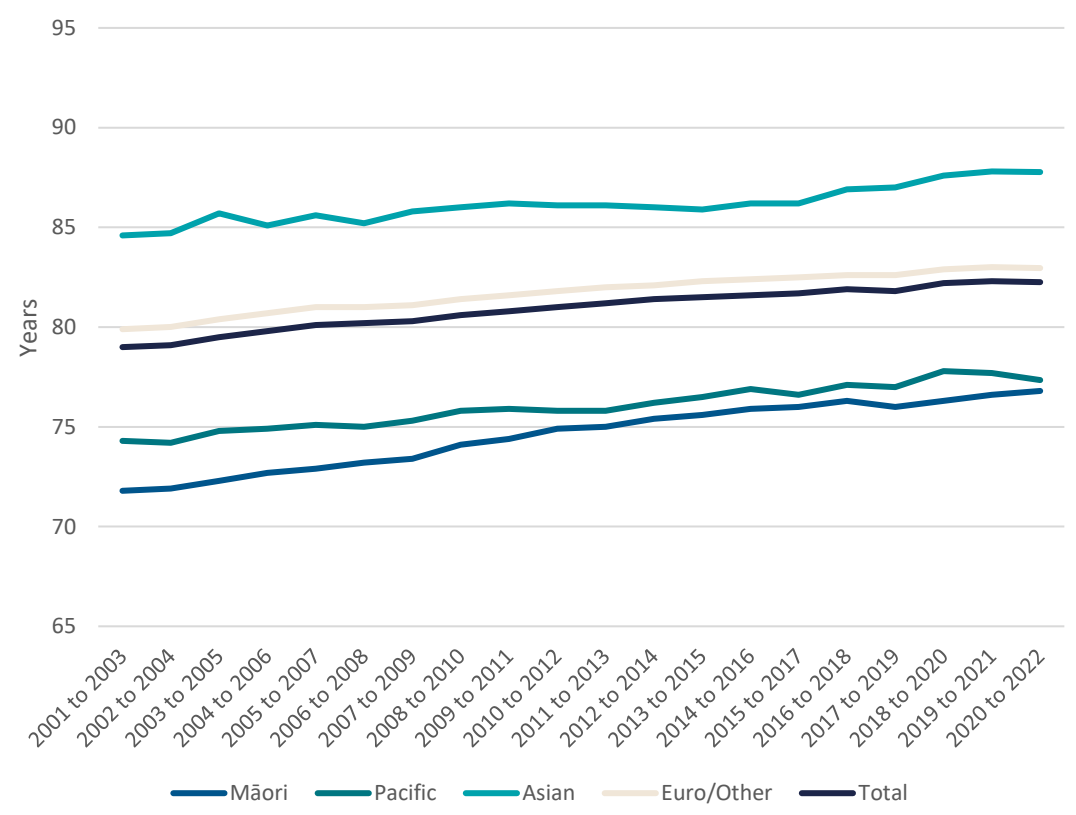
Source: HQSC



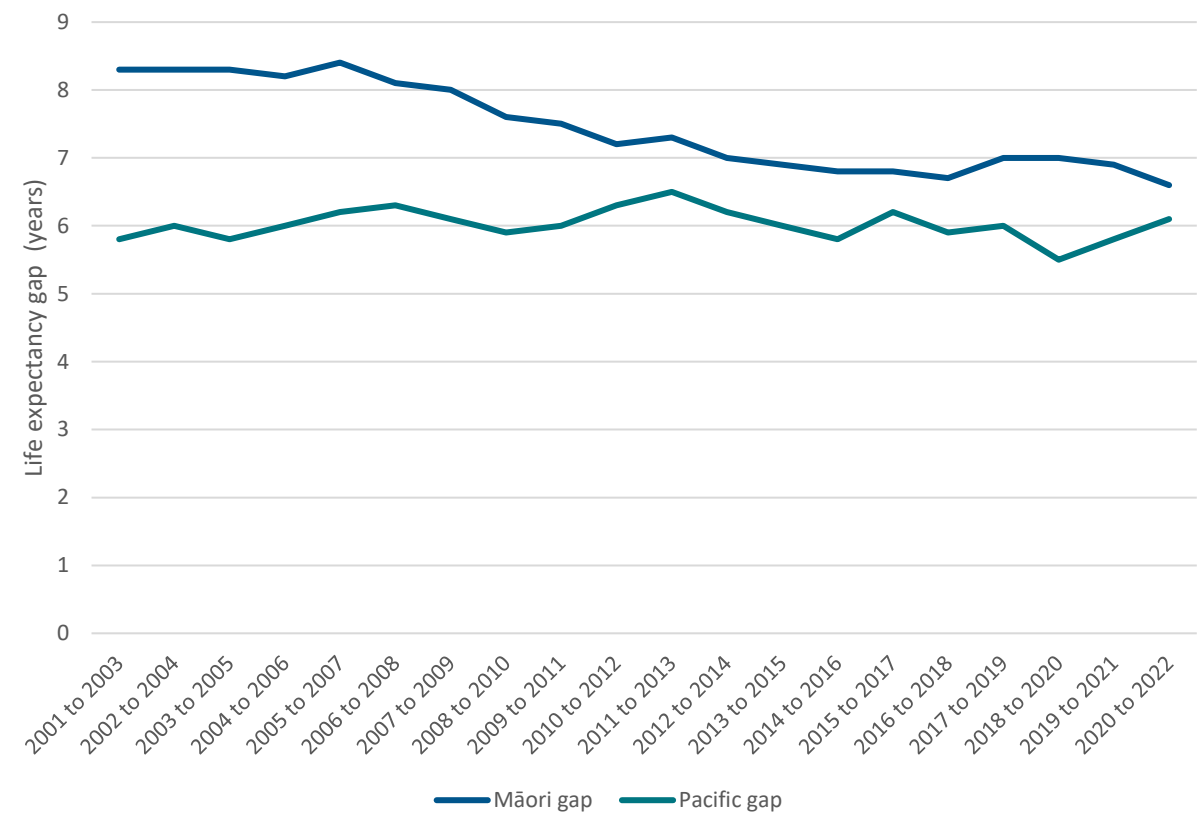
2. Life expectancy and the life expectancy gap



Trend in life expectancy at birth by ethnicity, national (2001-2003 to 2020-2022)



Trend in Life Expectancy Gap for Māori and for Pacific people, national (2001-2003 to 2020-2022)

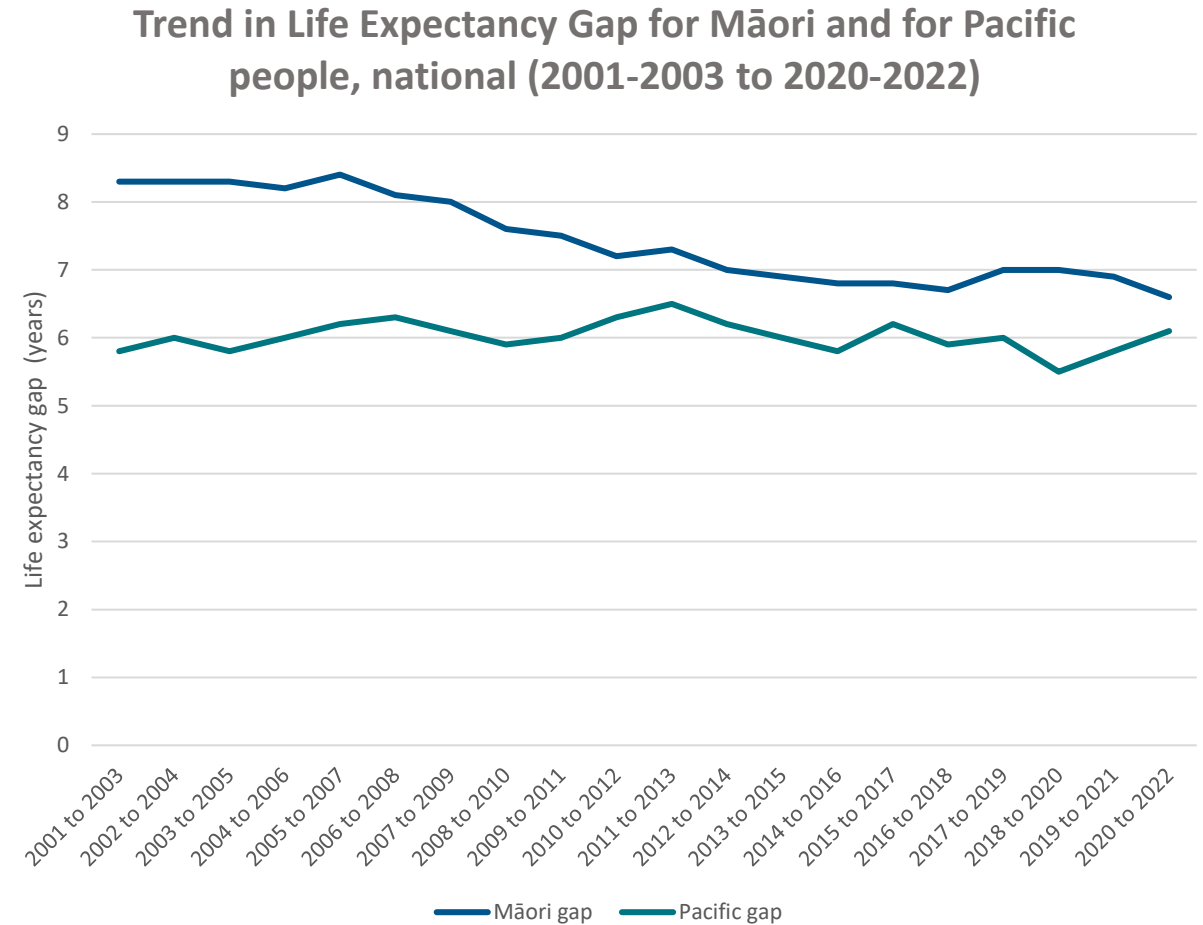


NMNP=Non Māori, Non-Pacific

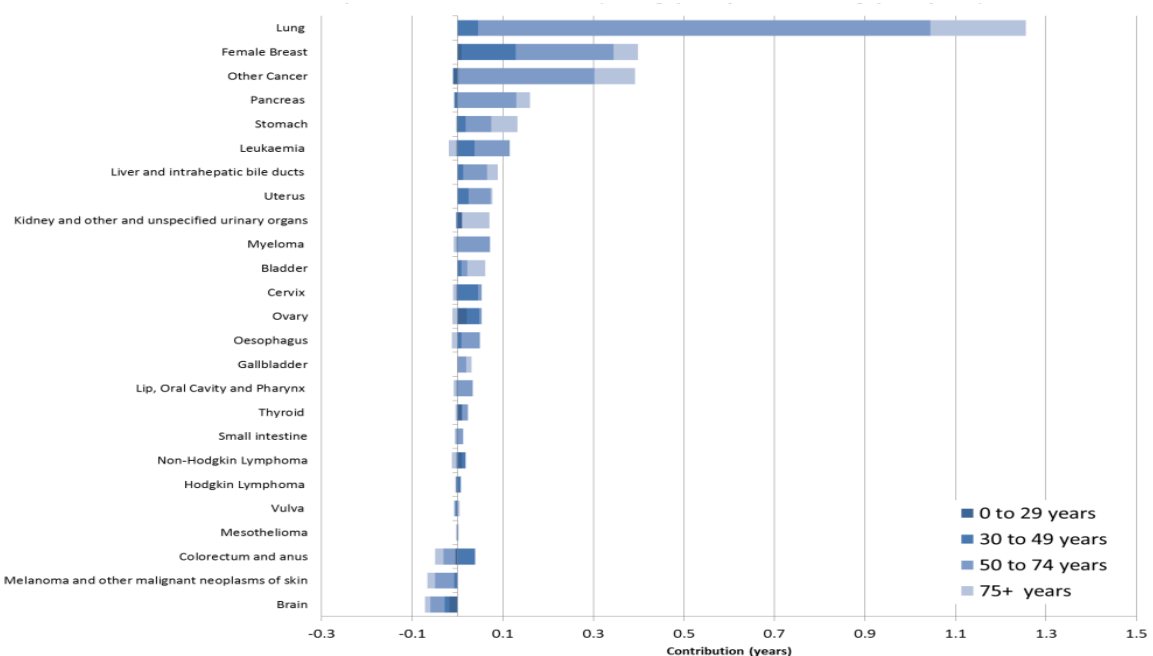
Source: M Walsh, LE Gap analysis, Equity team SII 2023

The top ten leading avoidable causes of death contributing to the life expectancy gap for Māori – Northern Region (contribute 3.8 years of the 8.3 year gap) 2018-2020

Avoidable cause	Contribution (years)
Coronary disease	0.9
Lung cancer	0.9
Diabetes	0.4
COPD	0.4
Land transport injuries	0.3
Suicide	0.3
Other accidental injuries	0.2
Stroke	0.2
Valvular heart disease	0.1
Stomach Cancer	0.1



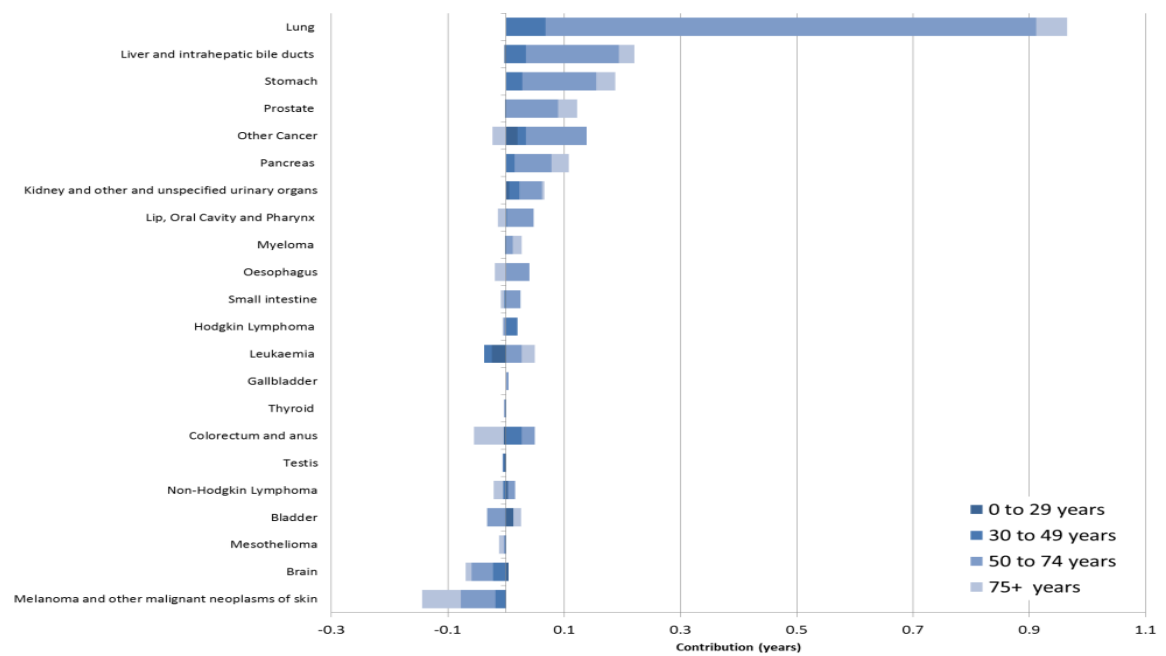
Māori women



*5.0 years of the gap attributable to non-cancer deaths not shown

- 2.8 years of the 7.8 Year gap
- Top two are Lung and Breast

Māori men



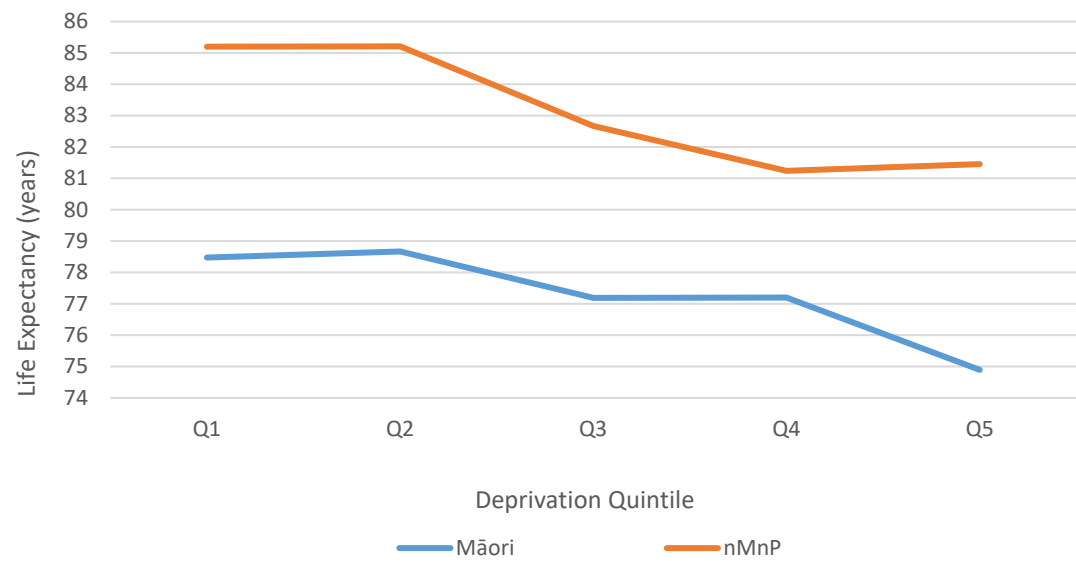
*7.0 years of the gap attributable to non-cancer deaths not shown

- 1.7 years of the 8.6 Year gap
- Top two are Lung and Liver

* Life expectancy is that of Māori across the Northern Region

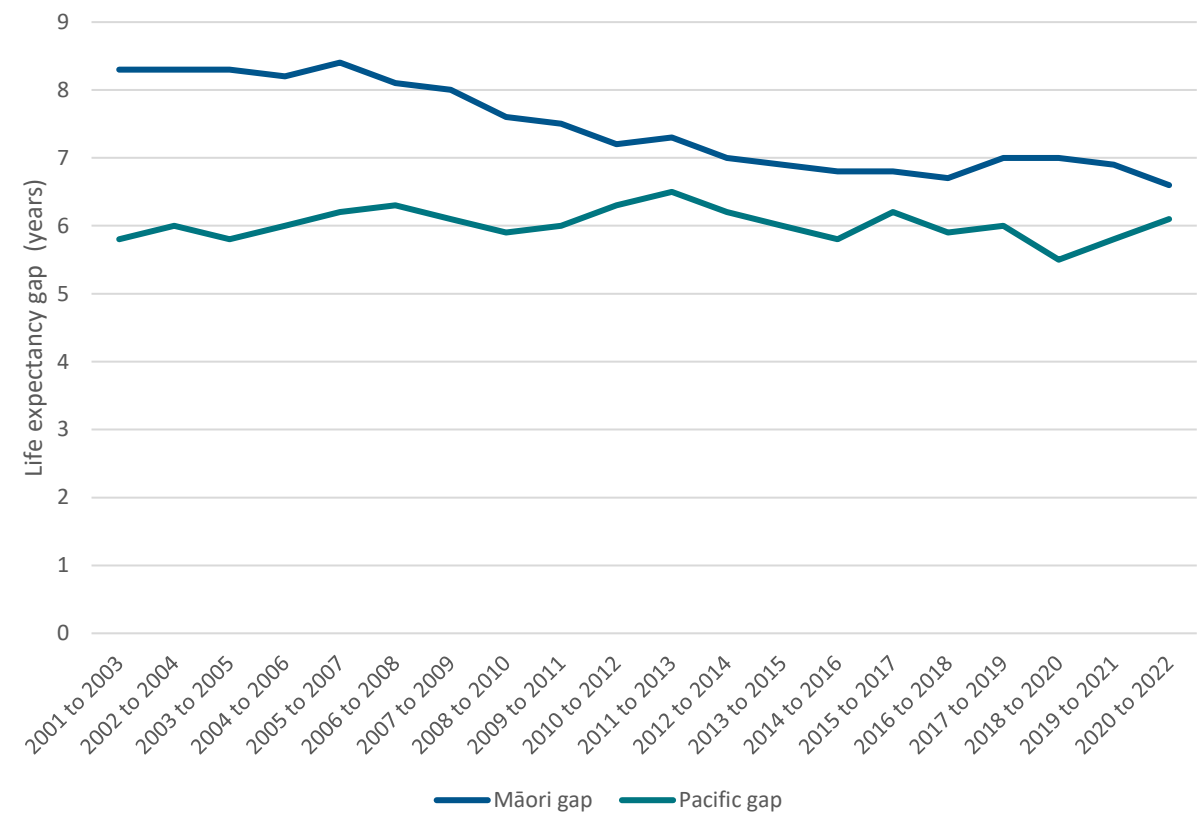
**Majority of "other cancers" are those with a cause of death from cancer with "unspecified site"

Life expectancy by ethnicity by deprivation quintile and by rurality (2020-2022)



GCH Classification	Maori	nMnP	Gap
U1 (Most urban)	76.5	83.8	7.3
U2	77.1	82.1	5.0
R1	76.4	82.6	6.2
R2	75.7	83.2	7.5
R3 (Most rural)	74.0	82.2	8.2

Trend in Life Expectancy Gap for Māori and for Pacific people, national (2001-2003 to 2020-2022)

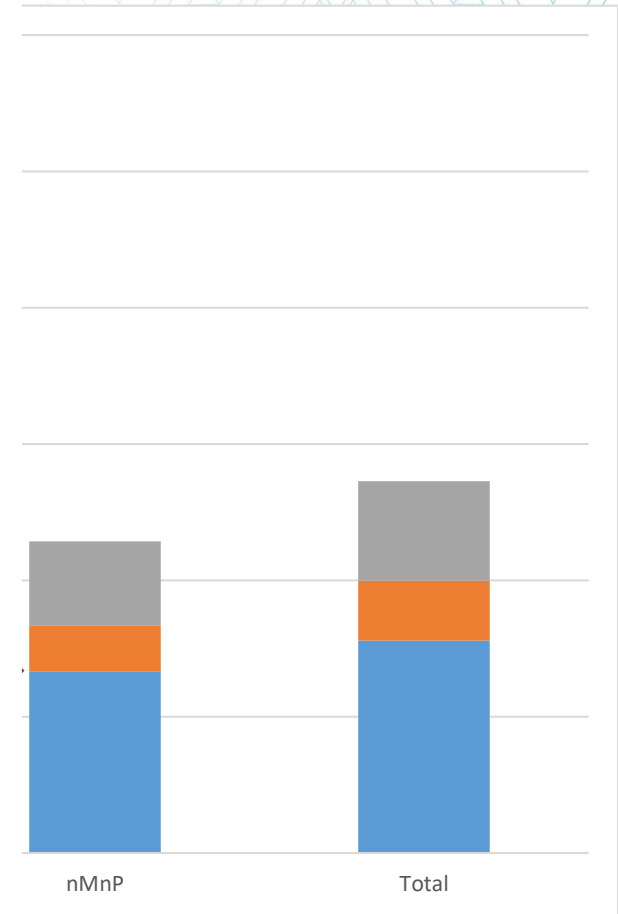
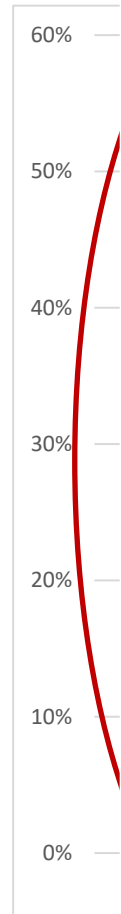


NMNP=Non Māori, Non-Pacific

Source: M Walsh, LE Gap analysis, Equity team SII 2023

Potentially avoidable mortality (2018-2020)

A total population view (and total population decision making) hides material differences for groups within the population

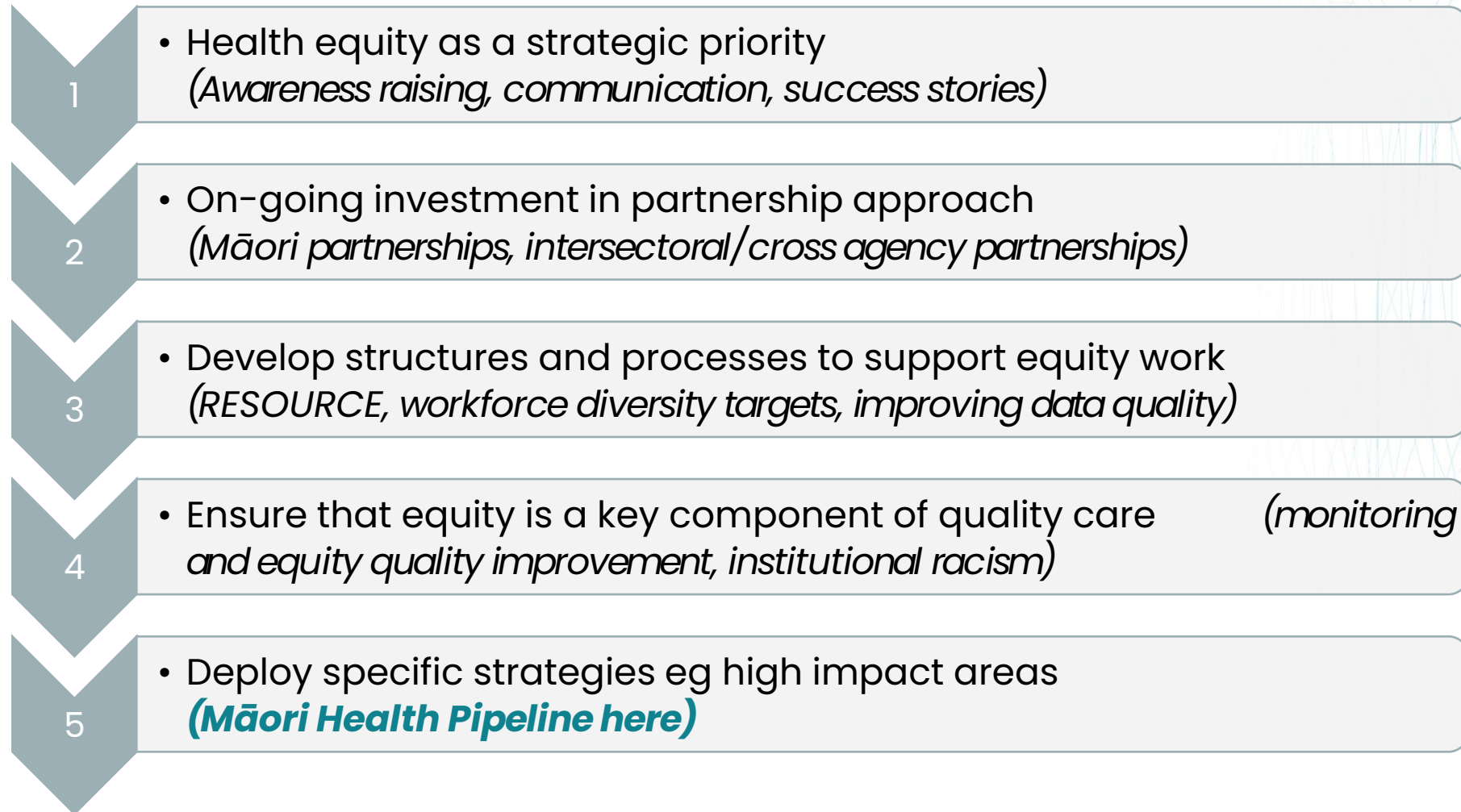


Note: * NMNP = Non-Māori Non-Pacific
Original analysis Michael Walsh and Corina Grey, NZMJ 2019 (updated 2023)

3. Māori Health Pipeline programme



Local district equity framework *



* Key elements of the Waitematā DHB Framework, based on the IHI framework

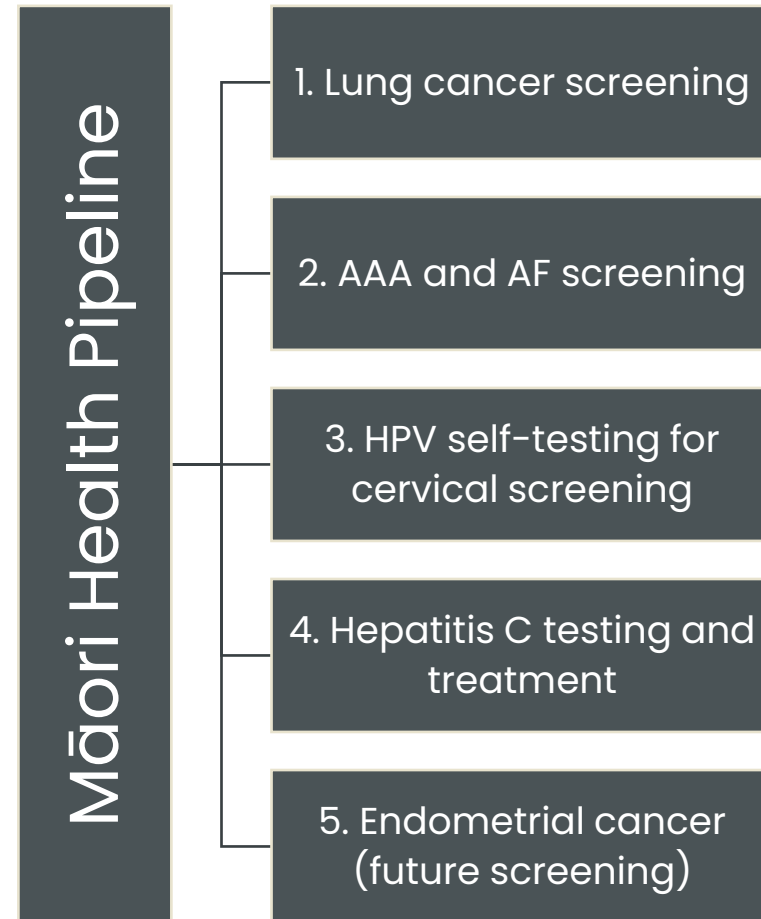
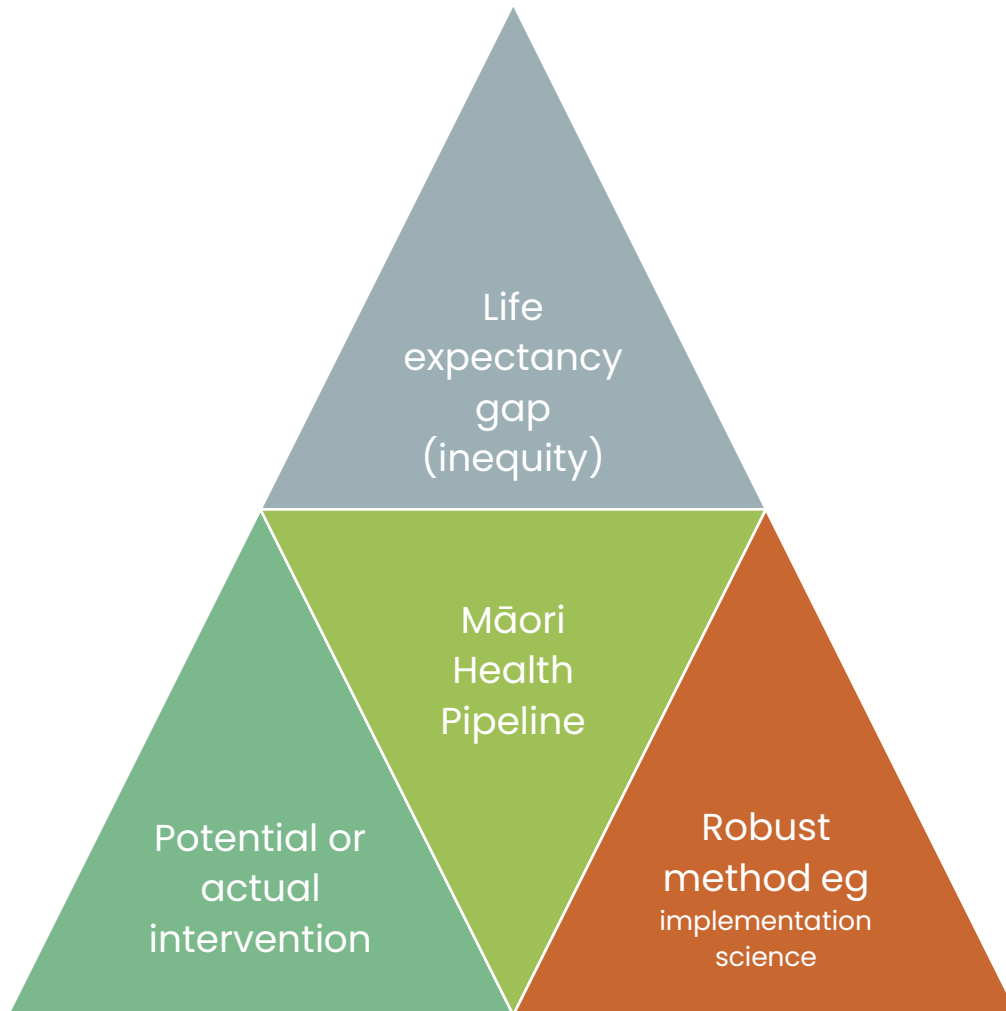
- Concept developed in 2015–16 out of:
 - Māori-specific Health Needs Assessment
 - A Life Expectancy Gap report and a follow up decomposition analysis
 - Northern region cancer equity analysis
- An overarching programme to **develop, test/research and establish** pieces of work that **accelerate Māori health gain** and the **closure of the life expectancy gap**
- Requested to look at prevention/**screening**/early detection interventions
- Focus on the life expectancy gap mean projects aimed in a particular direction
 - Public health / epidemiology approach – mainly cancer, cardiovascular, respiratory
 - Projects are either evidence based (**implementation science**) or designed to generate appropriate **policy-relevant evidence**
- Is **action** orientated, concrete pieces of work, most of it in mainstream services but **explicitly** incorporating Māori **values** and considering health **equity** at every step
- Is **not a total Māori health or equity response** (just one complementary part)

2017-18 Māori Health Plan Auckland and Waitemata District Health Boards



Ngā Pou o Te Whare o Waipareira
 The Whānau Centre Collective Impact Initiative – #tātou
Whānau Centre Health Needs Assessment
 May 2017





1. Scoping and start-up

- Concept description
- Understanding inequities and their drivers
- Literature review
- Intervention clarification
- Undertake preparatory work eg participatory approaches with potentially eligible participants and whānau

2. Prototype

- Testing the intervention in a research context
- Prevalence
- Basic / clinical research (efficacy or effectiveness)
- Adaptation or localisation to NZ setting
- Feasibility / acceptability

3. Settings or comparisons

- Implementation science research
- Test in specific populations eg ethnic groups or settings eg rural
- Test in specific models of care eg community provider, central hub, nurse-led
- Test against specific comparator groups eg RCT

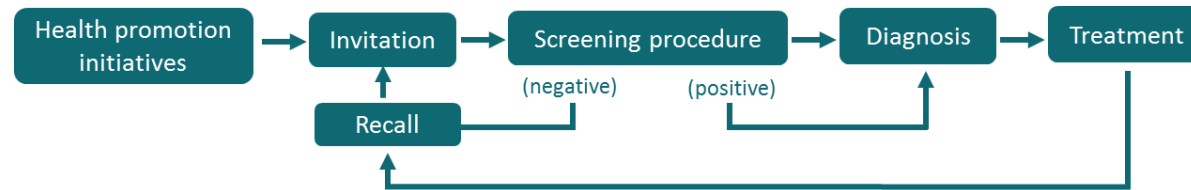
4. Scale-up

- Implementation science research
- For established interventions testing programme requirements eg workforce, IT, clinical pathways, co-benefits
- May aim to reach 5-10% of the eligible population if a priority for nationalisation

5. Nationalisation / handover to receiving service

- Planning work with the receiving service(s)
- Informing business case
- Aligning priorities, expectations, timeframes, budget
- Pipeline may 'hold' some service activity over this time until transition to a service/ programme

Example of Lung Cancer Screening (led by Professor Sue Crengle)



1. **Targeted screening:** Identifying asymptomatic people potentially at high risk of lung cancer (current or ex-smokers)
2. Confirmation of lung cancer risk (**risk assessment**, above risk threshold)
3. Invitation to undergo the screening test (**shared decision making**)
4. Lung screening with **low dose CT scan** (LDCT)
5. Results management:
 - a. Positive screen:
 - Referral of people who have CT scan findings that might be a LC (positive screening test) for further management and investigation – **nodule management**
 - Diagnosis and treatment for people diagnosed with LC (true positives)
 - **Incidental finding** management
 - b. Negative screen: People with negative screening test and those who had a positive screening test but no cancer on further investigation are **recalled** for repeat screening (eg 2 yearly)

Te Oranga Pūkahu: Lung Screening Study

Project Steering Committee

Professor Sue Crengle (Chair)
Aroha Haggie
Dr Rawiri Jansen
Dr Chris Lewis
Sharon McCook
Shelley Campbell
Dr Peter Sandiford

Dr George Laking
Dr Dale Bramley
Dr Rob McNeill
Dr Nina Scott
Dr Jacquie Kidd
Dr Mel McLeod

Technical Advisory Group

Professor Marg Wilsher (Chair)
Professor Mark McKeage
Professor Cristin Print
Dr Claire Hardie
Dr James Entwisle

Dr Chris Lewis
Dr David Milne
Dr Laird Cameron
Dr Paul Dawkins
Dr Rawiri Jansen

International collaborations

Australia
UK
Canada

Project leadership

PI Professor Dr Sue Crengle

Primary care advisory group

Professor Sue Crengle
Dr Peter Woolford
Alison Brown

Dr Rawiri Jansen
Dr Allan Moffitt
Dr Andre George

Te Hā Kotahi: Consumer Advisory Group

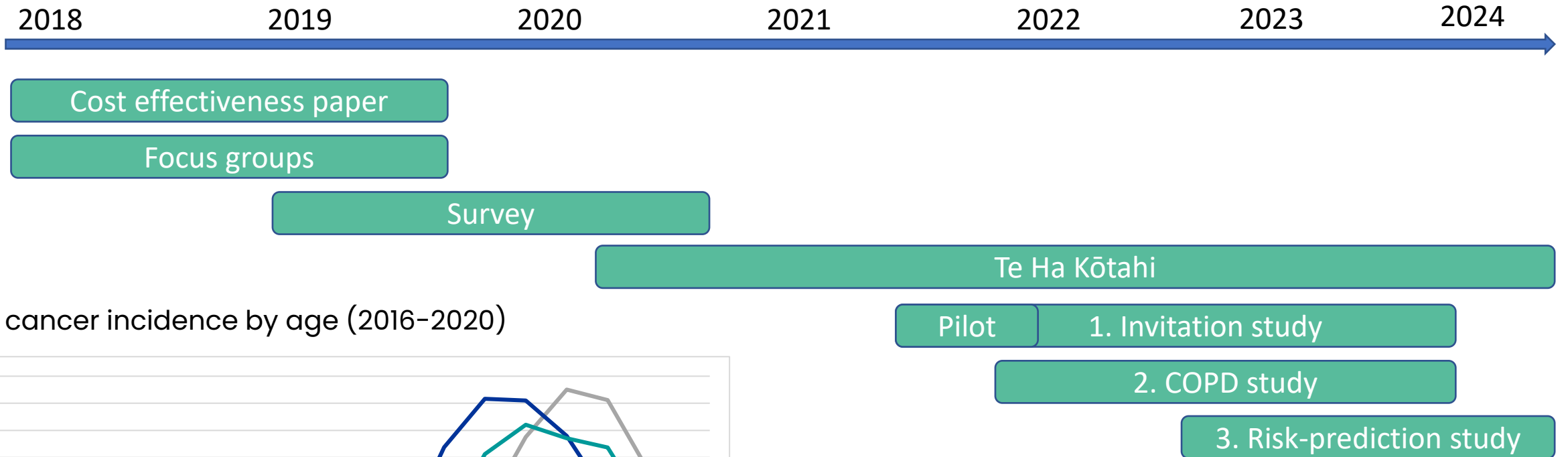
Whaea Doreen Law
Matua Russell Morey
Matua Rodney Richmond
Matua Melvin (Barrie) Wetini

Whaea Kathleen Winiata
Matua Terry Hibberd
Matua Horace Hartnett
Matua Carl Ross

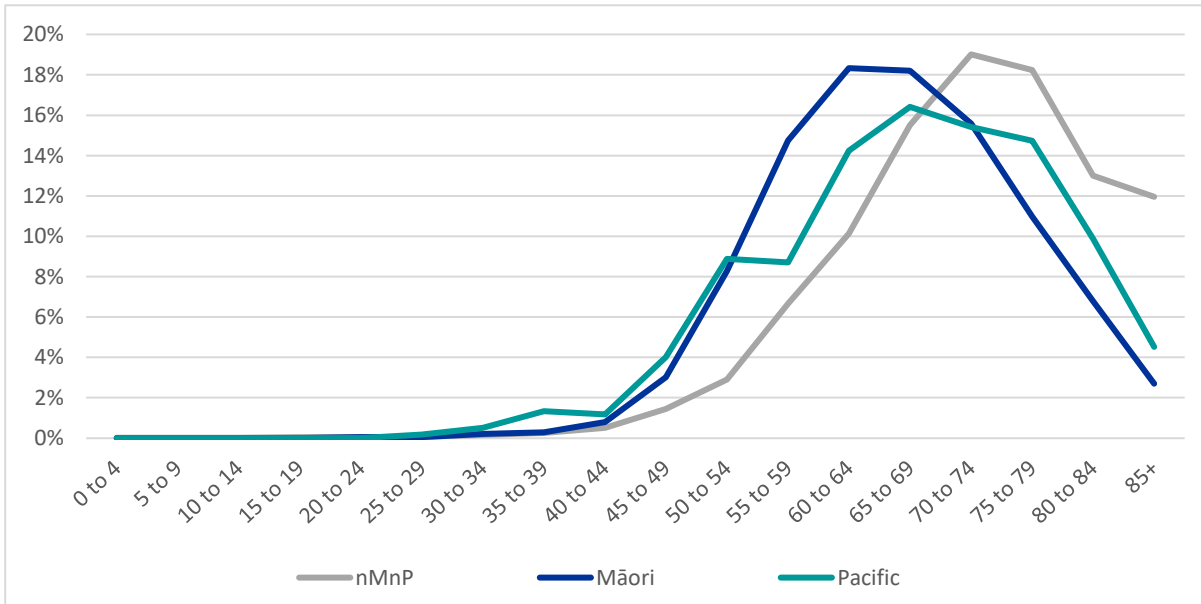
Academic linkages

University of Otago
University of Auckland
AUT
National Science Challenge

Te Oranga Pūkahu research programme



Lung cancer incidence by age (2016–2020)



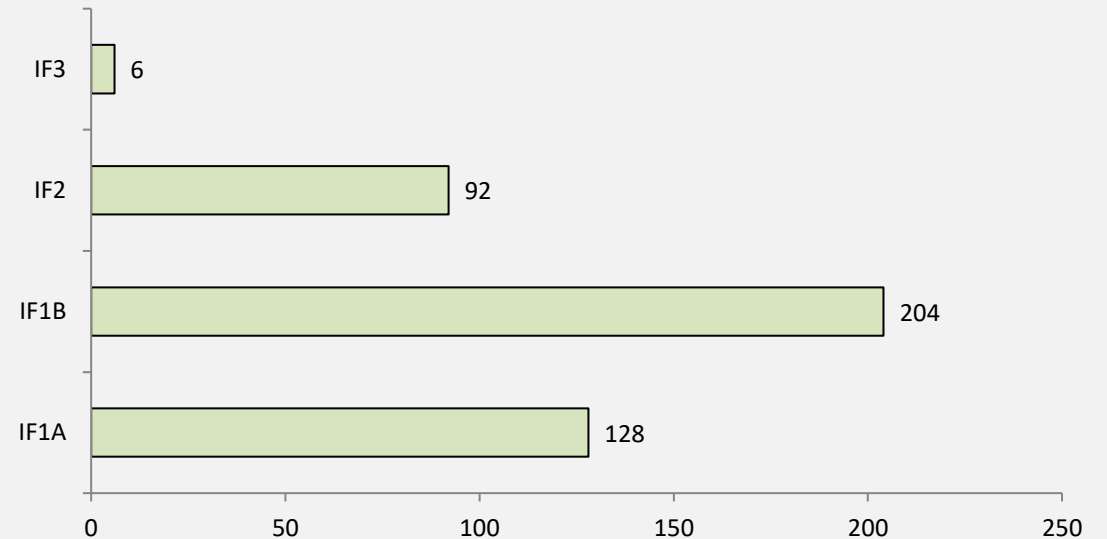
‘Designing-in’ equity to every aspect of planning for a national programme



Invitation trial results to date * unpublished

- 48 general practices now recruited (complete)
- Scanned >430 Māori participants
- Of those people risk assessed (using PLCOm2012 with 2% threshold), 54% were eligible for a CT scan
- Of those, 94% consented to a scan after shared decision making
- More than 90% agreed to blood tests (CtDNA)
- Of those who have had a CT scan, 65% have had no significant nodules
- We have identified 9 participants with lung cancers (~2%) and 6 participants with cancer at another site or requiring urgent follow up
- Approx 25% had incidental findings, most no follow up or primary care review (eg coronary calcification)
- Recruitment on track for completion Feb 2024

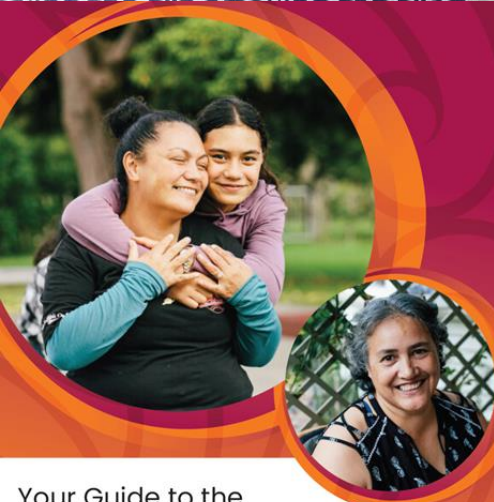
CT Results – Incidental Findings



My experience today from the entrance right through going out the door was warm and uplifting

4. Lessons learned





Your Guide to the
**Cervical Screening
 Self-test Study**
He Taonga, He Tapu

- The **purpose** of the work must be clear i.e. address an already identified Māori health or equity priority
- There must be an **intervention** – evidence based or generating ethnic-specific/Aotearoa-specific evidence
- International interventions **can be adapted** from an equity perspective successfully – takes substantial effort, expertise and attention paid to every aspect and ensuring it is whānau-centred, is 'easy' for people and all interactions from invitation through the session to follow up are accessible and culturally safe
 - Māori (ethnic-specific) **leadership** is critical – investigators, steering group, team workforce (workforce *are* part of the community)
 - **Relationships** and **positive participant stories** are at the heart of every piece of work
 - Pipeline model always starts with the perspectives of those **potentially eligible or people with lived experience** with qualitative work and include aspects of the **spectrum of consumer involvement** (focus groups/interviews through to co-design and co-production)



- Implementation opportunities to use the positive screening/ intervention session to integrate/offer other health interventions (**co-benefits**) especially for populations **underserved** by primary care and prevention programmes
 - eg smoking cessation, COPD, CVD risk assessment, other screening programmes
- Allow **sufficient time** and **offers** to ensure people have opportunity to participate (eg all projects use 5 contact attempts at different times of day and using different modalities)
- All programmes must have a **systematic resourced safety net** particularly for follow up of clinical or incidental findings and **free** follow up
 - eg CT nodule or incidental finding follow up, AAA specialist appointment and surgery, AF anticoagulant follow up, HPV positive result follow up
- All programmes include **wrap around support** to address the social determinants of health eg transport support



Questions for equity action (Equity QI)

- Do we have a common understanding of equity?
- Do we have a shared framework for thinking about equity?
- Do we know what equity 'endgame' outcome we are trying to achieve?
- Do we feel equipped on the 'how' of equity – leadership, service, team, individuals?
 - If not, what support do we need?
- Do we know our highest impact areas for change?
- If we have said we were going to do equity work:
 - Have we executed what we said we would?
 - Did it work? How do we measure ourselves/success? Share with others?
- Where are we going to start or what are we going to accelerate?



Detecting

Understanding

Reducing

Source: Kilbourne AM, Switzer G, Hyman K, et al. Advancing health disparities research within the health care system: a conceptual framework. American Journal of Public Health. 2006;96(12):2113-21

Ngā mihi

