The New Zealand Health Strategy 2016: whither health equity?

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ABSTRACT

New Zealand’s core health policy document—the New Zealand Health Strategy (NZHS)—was released in its final form in April 2016. This paper provides a critique of the strategy in particular, as it relates to health equity particularly for Māori. We introduce the five NZHS themes of—people powered, closer to home, value and high performance, one team and smart system—to focus on the aspirational goal of eliminating health inequities. Our critical framework is informed by Te Tiriti o Waitangi. We identified that the NZHS relies on the isolated efforts of committed individuals and organisations to achieve health equity and Te Tiriti engagement, rather than through a planned systems viewpoint. Evidence on health equity and Te Tiriti application suggests efforts need to be sustained, systematic and multi-levelled to be successful, rather than ad hoc and piecemeal.

Sixteen years since the launch of the initial New Zealand Health Strategy (NZHS)\(^1\) New Zealand is still burdened with health inequities between Māori and Pākehā New Zealanders\(^2\) entrenched through colonisation and more recent inequities between Pacific and European populations. Braveman and Gruskin\(^3\) define health equity as “the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants”. Inequities are avoidable differences in health between groups. Starfield\(^4\) argues inequity is built into health systems and manifests as disparities of health outcomes between dominant and marginalised groups. To address inequities, she argues organisational practices, policies and systems must re-orient to and embed attitudes, practices and procedures that champion and naturalise a culture that is purposely designed to enact health equity.

The publication of the revised NZHS\(^5\) was an important opportunity to rethink how the health sector can help to lift the health status of the entire population, within the available resources, towards the agreed goal of achieving equitable health and social outcomes. The Ministry of Health team are to be commended for their consultation efforts, talking face to face with over 2,000 people at meetings around the country. This paper offers a critique of the NZHS and its orientation to health equity in relation to Māori health, drawing upon Te Tiriti o Waitangi, a decolonisation lens\(^6,7\) and the framework of Health Promotion Forum, Treaty Understanding of Hauora in Aotearoa New Zealand.\(^8\) Our analytic framework articulates notions of social justice, partnership, self-determination and equity embodied in Te Tiriti as fundamental to, but inadequately realised, in NZHS 2016.

New Zealand health strategy

Building on NZHS 2000, NZHS 2016 revisited the guiding principles, retained a focus on health equity and acknowledged the importance of the Treaty of Waitangi. The detail of the NZHS centred around five interconnected strategic themes: i) people powered, ii) closer to home, iii) value and high performance, iv) one team and v) smart system. Under the rubric “Live well, stay well, get well”, the strategy proposes some signposts of where the sector should be in five and ten years’ time in relation to each of the strategic themes and then outlines a roadmap of how to achieve those goals.
People powered encourages and empowers people to become ‘health smart’, strengthening their health literacy and efficacy. The NZHS proposed achieving this through people being supported to make active choices through facilities such as virtual technologies.

Closer to home concerns developing integrated and targeted services close to where people live, learn, work and play. The NZHS aims to achieve this through integrated services and population-based initiatives that have the flexibility to be both universal and targeted for different purposes. These initiatives will include addressing the determinants of health.

Value and high performance is centred on a commitment to quality improvement, performance measurement, transparency and an integrated operating model. The NZHS committed to remove the infrastructural, financial, physical and other barriers to effective service delivery.

One team is about developing high-trust and flexible teams, and nurturing leadership. The policy envisages an effective workforce that collaborates with researchers, develops talent and leadership, and strengthens the role of families as caregivers.

Smart system is about engaging in evidence-based practice, innovation and utilising smart standardised technology. NZHS will ensure reliable accurate online health records that people can access and contribute to.

Discussion

This critique addresses some overall equity and Te Tiriti issues raised by the NZHS, and then more specifically addresses aspects of the themes of the NZHS.

The aspirational wording around health equity throughout NZHS typified by the responsibilising slogan “Live well, stay well, get well”, is heartening in one sense but obscures the longstanding gap between rhetoric and practice. For example, historically, hospitals promised as part of crown land purchases were never provided, and many other possible improvements for Māori communities such as sanitation and safe water supplies were denied and persist. In the contemporary setting, a study by Sheridan et al of DHB management of chronic health conditions observed slow translation of equity policy into practice, characterised by unsystematic patterns of change and inaction in the face of known inequity. A report from the Auditor-General identified only one DHB as compliant on their Māori health reporting. The NZHS does not appear to transform this existing ad hoc approach.

The Ministry of Health has commissioned a range of tools and frameworks that are able to detect and address inequities across the health sector. For instance, Cram’s framework for health equity for Māori identifies evidence-based recommendations for the whole health system, health providers and practitioners. These recommendations focus on the domains of leadership, knowledge and commitment and could have been incorporated into the NZHS roadmap. This would have ensured trackable equity targets rather than time-delayed, longer-term, high-level outcomes.

The Heath Equity Assessment Tool and the Whānau Ora Impact Assessment to a lesser extent are both used by government agencies as mechanisms for predicting the equity impact of decision-making. Their mandatory use within funding and policy decision-making by staff with the necessary cultural and political competencies, would strengthen equity efforts for investment and critically, disinvestment decisions.

Central to addressing health equity in the colonial context of New Zealand is engagement with Te Tiriti o Waitangi, as the founding document of our colonial state. Under Te Tiriti hauora (health) is recognised as a protected taonga (treasure) and equity (including in health) is guaranteed in Article 3. Although Treaty principles are embedded within health legislation and within the Māori health strategy—He Korowai Oranga, te Tiriti only makes a brief appearance in the NZHS as the basis of a “special relationship between Māori and the Crown”. The NZHS does not address Te Tiriti obligations explicitly and the persistence of health inequities between Māori and other New Zealanders is a serious breach of the agreement. As of April 2011, there have been over 89 Waitangi Tribunal claims related to the actions of Crown
ministers and officials in their administration of the health sector.

To improve enactment of Te Tiriti o Waitangi, the Ministry could be more explicit about how it engages with Māori as Treaty partners in administering the health sector. Being specific, enhances accountability and provides opportunities to monitor and track progress. The following questions adapted from TUHA-NZ (Treaty Understanding of Hauora in New Zealand) provide guidance.

- Article 1: How will hapū/Māori be involved in decision-making throughout the health sector?
- Article 2: How well are hapū/Māori aspirations reflected within the NZHS?
- Article 3: What specific actions will be undertaken to ensure health equity outcomes? How will they be monitored?
- Article 4: How well are Māori worldviews and values, including wairuatanga, reflected in the NZHS?

Institutional racism is a pattern of differential access to material resources and power by race, which advantages and privileges one sector of the population while disadvantage and marginalising another. It is a product of colonialism and remains a determinant of health that needs to be recognised as a critical site for action in any credible effort to address health inequities. With the growing body of evidence of racism within the New Zealand health sector, eliminating institutional racism should be central to efforts to achieve health equity. Establishing targets for change around this and investing in an evidence-based plan could have provided focus for the sector.

The disciplines of public health and health promotion have long been champions of health equity but unfortunately, the roles of these key approaches are minimised within the NZHS. Strategically there is strong evidence of the cost effectiveness of spending in public health as a key vehicle for pursuing equity. Money invested in keeping people well leads to considerable savings in clinical treatment costs later. When executed well, public health programmes produce healthy, resilient communities, but disinvestment needs to be redressed and new funding streams dedicated.

In relation to the specific themes of NZHS.

**People powered**—Underpinning this theme lie Western notions of people taking individual responsibility for their health that orientates to a neoliberal agenda of decreasing state accountability. Reframing the theme to incorporate meaningful treaty partnership that acknowledges indigenous community standpoints about historically sourced contemporary harms, collective responsibility and accountability around health, could strengthen indigenous engagement and outcomes.

**Closer to home**—From a public health perspective more local provision is a helpful reversal of the rationalisation of services and concurs with the long-held understanding that equitable services need to be appropriately situated for accessibility. This is an indirect acknowledgement of a significant body of work, which suggests self-determining, tailored approaches work best for Māori. In our analysis, this theme needs to encompass decolonisation initiatives and efforts to counter institutional racism.

From a Tiriti perspective the evidence demonstrating the impact of the social determinants of health, including colonisation and racism on health status, is robust and growing in relation to indigenous peoples. In relation to the determinants of health, the NZHS positively profiles the Ministry’s investment into healthier housing. However, direction on addressing other key determinants remains unclear, and being explicit would enable work on these imperatives to be tracked and evaluated.

**Value and high performance**—Health provider performance is routinely monitored by government. It is less transparent from a quality improvement perspective as to how health funders and policy makers ensure quality within their own practice. Research by Cram has identified multiple unexplored opportunities to strengthen the administration of the health sector that might reduce health inequities and improve outcomes from health investment.

Harris et al argue racism is a significant barrier to quality service delivery and contrary to genuine Te Tiriti based partnerships approaches. Mono-cultural practice or what Morrison calls unconscious
incompetence, seems wide-spread within the administration and service delivery of the health sector. Inequities in practice can be invisible to those managing the system. In terms of doing something different, based on a review of the evidence, Came and McCreanor recommend the development of a systems-wide plan for identifying, transforming and preventing racism as a barrier to health equity.

One team—The Ministry’s ongoing investment into Māori health leadership has been positively evaluated and in Tiriti terms is a constructive contribution to decolonisation and Māori self-determination. In considering the capacity and capabilities of the health sector in relation to health equity, generally it seems useful to invest in strengthening political and cultural competencies within the sector. These core competencies should be applicable to people functioning at all levels of the health system including decision-makers and policy makers.

The NZHS has retained Māori representation on district health boards (DHB) to enable Treaty partners’ input into health decision making. Structurally strengthening Māori and Pacific input into health policy and decision-making through representation on all health advisory and reference groups might strengthen outcomes.

Smart system—To achieve equitable health and social outcomes, notions of evidence need to extend beyond Western bio-medical definitions to incorporate mātauranga Māori understandings of what protects and threatens health. Best practice is a term widely used in the health sector and often refers to international frameworks as generated in the Northern hemisphere in studies that include no indigenous theorising or analysis. If we don’t know what works best in a New Zealand context, it seems prudent to commission local research so we can ensure that interventions actually decrease health inequities. Given that access to technology comes with its own built-in inequities, careful attention is needed to avoid having this imperative further exacerbate difficulties for Māori and other populations.

Conclusion

The stated high-level policy commitment to health equity in the NZHS engenders hope in our dynamic socio-economic, political and cultural environment. The political challenge facing the health sector is how to move the aspirations of the NZHS into everyday praxis. Research into health equity suggests that fragmented approaches will fail and that efforts need to be sustained, systematic and multi-levelled to be successful. The NZHS ignores this evidence and instead relies on the isolated efforts of committed individuals and organisations rather than addressing equity from a planned, systems viewpoint.

In the context of New Zealand, deep engagement with Te Tiriti o Waitangi, particularly addressing the specifics of the implications of Te Tiriti articles, needs to be the core platform of the NZHS and is essential for any credible effort to reduce inequities between Māori and non-Māori. Māori need to be structurally and consistently engaged in decision-making about health policy and investment decisions. The work practices of Crown ministers and officials needs to align with Te Tiriti to prevent further treaty breaches and Waitangi Tribunal proceedings.

Māori and Pacific communities have solutions about how to improve their respective health status. A commitment to Māori and Pacific-led solutions is missing in the NZHS. Institutional racism is a determinant of health for Māori and Pacific communities and a barrier to health equity. The NZHS was a chance for the government to get its house in order and this opportunity has been squandered.
Competing interests:
Nil.

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15. Te Tiriti o Waitangi refers to the Māori text of the Treaty of Waitangi.


