

SUMMARY PAPER

Applying the Health Equity Assessment Tool: Findings from six case studies

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Public Health Unit, Taranaki District Health Board



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EXECUTIVE SUMMARY

Health Equity Assessment (HEA) is a tool to understand health inequities and identify actions to reduce or eliminate these inequities. This report summarises the findings of the six HEA completed by the Public Health Unit (Taranaki PHU) and the key actions identified needed to improve health equity. Significant overlaps were found across all six HEA in both the groups experiencing health inequities and the recommendations for how health providers could reduce or eliminate these health inequities. This report recommends key actions that could be used in planning, purchasing, commissioning and delivery of other Taranaki health services to tackle health inequities.

This paper used multiple case study design to examine the six HEA of Taranaki health services and programmes that were completed by Taranaki PHU between September 2016 and June 2019. These HEA were:

1. Breastfeeding Welcome Here Project
2. Immunisation in Taranaki
3. Kidsafe Under Fives Falls Injuries in Taranaki
4. Community Oral Health Services for Children Under Five
5. Breast Screening Participation in Taranaki
6. Lead Maternity Carer (LMC) Registrations in First Trimester of Pregnancy

Recommendations for improving equity

Pathways for promoting equity were identified across the HEA case studies, including:

- Increasing the Māori workforce
- Improving cultural safety
- Greater consideration of equity and collaboration in planning (enhancing Māori voice in planning)
- Provision of kaupapa Māori services
- Improved equity data reporting and monitoring,
- Greater integration of Te Reo Māori
- The importance of community-based kaiwhina to support Māori engagement with health services.
- Use analysis of health equity, including methods such as the HEAT tool, when planning health services and embed this into planning, commissioning and service purchasing.

To respond to what is clearly shown as wide-spread and persistent inequities for Māori, low socio-economic groups and people living in South Taranaki, consideration of health inequities is fundamentally essential in all routine health service and programme planning in

Taranaki. The HEAT Tool can assist with applying a critical health lens to detect how 'mainstream' services are acting to privilege some groups over others and to plan how to redress this.

Key inequities

Ethnic, geographic and socio-economic inequities were identified in every case study. These health inequities were identified as impacting disproportionately upon:

- Māori populations
- People living in higher deprivation
- People living in South Taranaki
- People living in rural areas
- Those living greater geographical distances from health services

The HEA reports consistently recognised the intersecting nature of inequities across ethnic, geographic and socio-economic factors. Socio-economic disadvantage was identified as a key contributor to health inequities in all HEA, and related to other factors such as:

- Poverty
- Lower levels of education
- Housing and transiency
- Significant financial pressures and life stresses
- Working conditions impacting on ability to attend appointments.

The six case studies found that current health service and programme delivery advantages Pākehā, high socio-economic groups and people living close to health services, particularly those residing in New Plymouth. Across all HEA case studies Non-Māori, specifically New Zealand Pākehā, were viewed as advantaged. The way in which health services and programmes are delivered was consistently viewed as most culturally appropriate for Pākehā, based on mono-cultural, Western, bio-medical understandings of health.

The lack of culturally safe practices of staff to appropriately meet the needs of Māori was evident, with delivery commonly described as culturally inappropriate. A frequently reported finding was that staff delivering services lack adequate awareness and understanding of the cultural needs of Māori populations. The lack of Māori staff in the health workforce was also highlighted as a driver of inequities.

Racism and discrimination within the system were evident, with fear of discriminatory treatment, negative past experiences and mistrust in the health system apparent.

Implementation of health equity approach at Taranaki DHB

Since 2016, the Taranaki PHU has been applying the Ministry of Health (MOH) 2008 Health Equity Assessment Tool (HEAT) over existing health services and programmes. As part of this work, Taranaki District Health Board (Taranaki DHB) has developed its own approach to

applying the HEAT tool. This approach uses multiple sources of evidence (including data analysis, health consumer voice, stakeholder participation and literature review) and is underpinned by a strong emphasis on Māori participation. Each HEA produces a summary report with equity-focused recommendations to inform future planning and delivery.

While the Taranaki DHB has made a clear commitment that it will use the HEAT tool to promote equity in planning, stronger organisational policy is required regarding associated expectations (such as applying HEAT and implementing recommendations), a framework to clarify how this will be achieved in practice, and a strategy for building the capacity of staff to undertake this work.

Some of the recommendations of the HEA, such as increasing the number of Māori in the workforce, relate to complex, systematic issues, which require long-term solutions. This paper highlights an opportunity to place an equity lens over the recruitment of Māori staff, and highlights the need for a strategy to further develop existing staff cultural safety practices and Te Reo Māori skills. It also demonstrates the need to embed equity-focused planning and improve equity data reporting and monitoring.

Overall, the HEA conducted at Taranaki DHB have provided an evidence-based, strong impetus for change. An example is the use of the findings from HEA to disestablish the Taranaki PHU Breastfeeding Welcome Here programme, which was clearly not meeting the needs of Māori and was doing little to reduce the inequities in breastfeeding rates between Māori and Non-Māori. The HEA supported the establishment of a kaupapa Māori antenatal programme, Hapū Wānanga, which has improved the reach of antenatal education to wāhine Māori, their partners and whānau. This is a shining example of a 'mainstream' health organisation applying a critical health equity lens and committing to equity-focused change, resulting in a dramatic change in practice and allocation of resourcing to advance Māori health outcomes.

While not all HEA have led to such positive change, clearly this can be done. Privileging the voice of those who have lived experience of health inequities in HEA is key to re-orientating health services to reduce inequities and better meet consumer need.

BACKGROUND

Health equity

The health care sector is a vital determinant of health in itself and a key resource in improving health in an equitable manner (Baum et al, 2009). As a sector, health has a responsibility to recognise and reverse its propensity to generate health inequities. To do this, it must consider the wider socio-economic, cultural and environmental conditions that exist for consumers of health services, and impact on their ability to engage in available health services.

Health equity is the absence of systematic disparities in health between groups with different levels of underlying social advantage and disadvantage (Braveman & Gruskin, 2003). The New Zealand Ministry of Health (MOH, 2019) has recently offered the following definition of health equity:

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
(Ministry of Health, 2019, p7).

Health equity lens

Promoting health equity in planning processes and decisions is increasingly accepted as a shared responsibility in which the health sector has a key leadership role. However, research has found that, in New Zealand, equity is not routinely and systematically incorporated into planning decisions (Sheridan et al., 2011). Applying a 'health equity lens' in planning is an approach that draws attention to existing inequities (for example by ethnicity, geographic location and socio-economic status) and considers the distributional impact of actions on societal groups which already experience differential levels of advantage.

A health equity approach urges planners to "look beyond the health impacts for the overall population to systematic health differences in sub-groups of the population" (Simpson, Mahoney, Harris, Aldrich, & Stewart-Williams, 2005, p. 776). As a result, resources can be redirected towards strategies that have demonstrable equity positive outcomes (Tugwell et al., 2006). Health equity tools are acknowledged as a promising strategy to assist users to view health planning through a 'health equity lens' and enhance the consideration of equity in decision-making (Haber, 2012; Pauly et al., 2018). From such an assessment, informed decisions can be made about how to build and strengthen health policies, programmes and services.

Health Equity Assessment Tool

In Taranaki, there are significant disparities in health, particularly for Māori populations. Taranaki DHB, a regional hospital, public health service and funder of health services, is committed to creating a fairer society where everyone has the opportunity for good health

and where the health system meets the needs and aspirations of Māori (Taranaki District Health Board, 2018). Eliminating health outcome differences which are unnecessary, avoidable, unfair and unjust is a core focus of Taranaki's DHB's work (Taranaki District Health Board, 2018). Taranaki DHB has identified the MOH Health Equity Assessment Tool (Signal et al, 2008) as its preferred tool for undertaking health equity assessment (Taranaki District Health Board, 2018). This is consistent with MOH guidance to DHBs to utilise the various health equity tools available to improve the consideration of health equity in planning (Ministry of Health, 2018).

Developed in 2008, the HEAT tool consists of a set of 10 questions that enable assessment of policy, programme or service interventions for their current or future impact on health inequalities. The questions cover four stages of policy, programme or service development:

1. Understanding health inequalities
2. Designing interventions to reduce inequalities
3. Reviewing and refining interventions
4. Evaluating the impacts and outcomes of interventions

The HEAT Tool is designed to be used flexibly as a planning tool to meet the needs of the user. It should ideally be used prospectively, but can be applied to any stage of health service planning and delivery. The 10 HEAT Tool questions are:

1. What inequalities exist in relation to the health issue under consideration?
2. Who is most advantaged and how?
3. How did the inequalities occur? What are the mechanisms by which the inequalities were created, maintained or increased?
4. Where/how will you intervene to tackle this issue?
5. How will you improve Māori health outcomes and reduce health inequalities experienced by Māori?
6. How could this intervention affect health inequalities?
7. Who will benefit most?
8. What might the unintended consequences be?
9. What will you do to make sure the intervention does reduce inequalities?
10. How will you know if inequalities have been reduced?

Taranaki application of HEAT

Since September 2016, the Taranaki PHU has undertaken HEA by applying the HEAT tool to priority health services and programmes identified by the Taranaki DHB. To inform the HEA analysis, the Taranaki PHU developed its own approach to applying the HEAT tool, which incorporates multiple sources of evidence including data analysis, health consumer voice, stakeholder participation and literature review, and is underpinned by a strong emphasis on Māori participation. Each HEA produces a summary report with equity-focused recommendations to inform future planning. These summary HEA reports are disseminated to key stakeholders and are publically available on the Taranaki DHB website (Taranaki District Health Board, 2019).

Between September 2016 and July 2019, six comprehensive HEA were completed. The HEA were conducted by a team of Public Health staff with backgrounds in health equity, Māori health, data analysis, health promotion, and research and evaluation. Professional mentoring and peer review of these assessments has been provided by HEAT Tool contributing authors, Professor Louise Signal and Associate Professor Bridget Robson from the University Of Otago Department Of Public Health. Following the completion of each HEA report, the Taranaki PHU provided ongoing assistance to services and key stakeholders to undertake collaborative planning in response to the HEA recommendations, and the HEA reports were made publically available on the Taranaki DHB website.

While each of the respective HEA have been undertaken in isolation to each other, there are likely to have been common findings across these HEA reports. It is hypothesised that across the multiple HEA reports there will be commonly identified factors contributing to inequities and, subsequently, common entry points for recommended interventions. Reporting these commonalities across this body of work will provide the DHB with valuable direction on the areas necessitating greater effort to address health inequities in Taranaki. This paper seeks to provide this information.

Research questions

The overarching research question this paper seeks to answer is *'Overall, what did Taranaki DHB learn from applying the HEAT tool?'* More specifically, this paper will respond to the following questions:

1. What common contributors to health inequities in Taranaki have been identified by applying the HEAT tool?
2. What common pathways to promoting health equity in Taranaki have been identified by applying the HEAT tool?

The following HEA reports will be examined in this paper.

1. Breastfeeding Welcome Here Project
2. Immunisation in Taranaki
3. Kidsafe Under Fives Falls Injuries in Taranaki
4. Community Oral Health Services for Children Under Five
5. Breast Screening Participation in Taranaki

6. Lead Maternity Carer (LMC) Registrations in First Trimester of Pregnancy

As stated earlier, the objective of this paper is to bring attention to the priority areas of health service planning and delivery demanding greater attention in order to tackle health inequities in Taranaki. Therefore, the intended use of this paper is that the findings will be shared with Taranaki DHB senior management and Board members, respectively, to guide further action.

METHODOLOGY

A retrospective case study design was used to draw findings from multiple case studies, aggregating information and synthesising the findings from six HEA cases. A simple criteria was established for selecting the case studies - all comprehensive HEA reports that had been completed by Taranaki PHU and had been made publically available would be reviewed. Six HEA were identified that met the criteria and all six were included in the study. Due to the descriptive nature of the research questions and limited time and resource, the agreed method of data collection was limited to document analysis of the six HEA summary reports. This method was deemed suitable for the research questions, which seek to summarise the content of HEA reporting as opposed to appraising the HEA itself. It is noted that a process and impact evaluation of a sample of the case studies is currently being undertaken that includes key informant interviews and feedback from workshop participants, which will provide valuable learning to the DHB on the process of HEA and the impacts of HEA.

To complete this paper, an individual Public Health Advisor undertook the analysis and produced the summary report, which was peer-reviewed by two Public Health staff members. All staff that had input to this paper were either contributing authors or had some involvement with the HEA projects. It is, therefore, likely that this knowledge and experience of the HEA concerned influenced the subjectivity of the findings. Document analysis was completed using a combination of three of the HEAT tool questions and the two research questions to organise findings. Data was extracted from each report individually and coded using an inductive approach. A colour coding system was used to identify common codes across cases. From the codes, common themes were generated. In addition, key information was extracted from the reports to provide background summaries of each case study.

RESULTS

The results section is organised into two sections. Firstly, an overview of each case study is given to summarise the purpose of the HEA, the evidence collected to inform the HEA analysis and a sample of the key findings of the final report. The second section reports the findings across the six case studies, describing the health issues assessed, objectives of the case studies, sources of evidence used, then summarising the common 'drivers of inequities' and 'pathways to health equity', as documented across the case studies.

Case Studies

CASE STUDY 1 - Breastfeeding Welcome Here Project

A health equity lens was applied to the Taranaki DHB's Breastfeeding Welcome Here (BFWH) Project in 2016 to assess its impact on inequity in breastfeeding rates in Taranaki. In addition, this exercise also aimed to identify other effective interventions that could contribute to improving equity in breastfeeding in Taranaki. The HEA analysis was informed by analysis of breastfeeding data, rapid literature review, a stakeholder workshop with 14 participants, four key informant interviews and two focus groups with mothers based in South Taranaki.

While the HEA was intended to review the BFWH, it became evident early in the process that the wider issues that impact on inequities in the breastfeeding rates also needed to be addressed and the HEA was an opportunity to better understand this need. Existing breastfeeding data showed that at all the milestone ages, Māori were at least 20 percent away from reaching the breastfeeding rates targets, while Non-Māori were much closer or exceeding targets. Infants discharged from Hawera Hospital were found to be three times more likely to be artificially feeding on discharge than those discharged from Base Hospital.

The application of HEAT to the BFWH Programme explicitly found that the BFWH project, on its own, would not contribute significantly to addressing inequity in breastfeeding in Taranaki. Key themes to emerge in this HEA were a lack of breastfeeding support services in South Taranaki, difficulties with transport for South Taranaki populations, a lack of cultural appropriateness and awareness of maternity staff, and the need for kaupapa Māori antenatal education that focuses on re-establishing breastfeeding as tikanga Māori practice.

The report suggested that Taranaki PHU should explore additional opportunities to affect change in Taranaki breastfeeding rates for Māori and South Taranaki mothers beyond BFWH. A range of other recommendations were made to the Taranaki DHB including increasing lactation support hours in South Taranaki, and establishing the Hapū Wānanga programme (a kaupapa Māori antenatal education programme held at marae). The report concluded that, to be effective in addressing inequity in breastfeeding rates in Taranaki, it is essential that the Taranaki DHB prioritises its breastfeeding promotion resource to focus on wāhine Māori and South Taranaki mothers.

CASE STUDY 2 - Immunisation in Taranaki

In 2017, the Taranaki PHU led a HEA process of the Taranaki childhood immunisation service, seeking to understand the existing inequities in childhood immunisation coverage in Taranaki and identify service improvement opportunities that can be driven by Taranaki DHB to address existing inequities. The HEAT Tool was applied using a participatory approach at a stakeholder workshop and in key informant interviews. Consumer voice input was collected at a caregiver focus group in South Taranaki and through telephone interviews with parents who were on the immunisation outreach lists. A literature review examined published research on effective interventions that address inequities in immunisation.

The HEA highlighted existing geographical, ethnic and socio-economic inequities in achieving timely immunisation coverage of children in Taranaki. It found that tamariki Māori experience notable inequity at a number of key milestones and are over-represented in the Outreach Immunisation Service (OIS). Socio-economic and geographic inequities were evident, with areas of higher deprivation having the highest rates of infants on the OIS list. This included the areas of Waitara, Marfell and Manaia.

Significant barriers were identified for families living in Waitara to accessing wider general practice services. It was found that more than two thirds of infants on the OIS list who live in Waitara are either not enrolled at a general practice or are enrolled in one outside of the Waitara area, highlighting access to general practice as a key determinant of immunisation inequities for this population. While this is likely due to a range of system factors, it is noted that the local general practice in Waitara was not enrolling new patients at the time of this assessment. As childhood immunisation is a good indicator of equity in child health, this report also highlighted the broader issue of inequity in access to primary health care in Taranaki. Key themes to emerge from this assessment include primary health care access barriers such as enrolment, communication and transport; the importance of community partnerships and representation in immunisation service governance; health literacy and service enhancements for Māori in general practice; practice level equity coverage monitoring; encouraging re-engagement into primary health care by the OIS; antenatal focus on immunisation with whānau members; and the value of Māori consumer input into service planning.

CASE STUDY 3 - Kidsafe Under Fives Falls Injuries in Taranaki

This 2017 HEA applied a health equity lens to three Kidsafe Taranaki Trust (Kidsafe) strategies to prevent serious fall injuries to children under five in Taranaki. It sought to understand the existing inequities in under fives fall injuries in the Taranaki population, assess the contribution of the current delivery of Kidsafe strategies to reducing inequity, and identify opportunities for Kidsafe to contribute to the elimination of inequity in under fives falls injuries in Taranaki.

The HEA drew on evidence collected at a stakeholder workshop, three key informant interviews and existing published research on the effective interventions to prevent child falls injuries. This HEA demonstrated that the national picture of inequity in serious falls injuries to children under five years old is not as strongly evident in the local Taranaki data. However, due to a range of limitations to local data analysis and recognised barriers around access to health services in parts of Taranaki, it suggested that measures to prevent child injury need to respond equitably to ethnic, socio-economic, geographical and gender populations that experience inequity on an established national level.

Two of the three current Kidsafe strategies to prevent child falls injuries were assessed to be promising approaches for addressing inequity, particularly for tamariki Māori and low income families. However, a number of areas for improvement, particularly around project reach, were highlighted. One project was assessed to have limited likelihood of addressing inequity for key population groups and, despite the potential to strengthen its equity approach, the benefits of this intervention would never be fully shared equitably across

population groups due to its design. The HEA suggested Kidsafe clearly define a specific project audience based on inequity; highly target efforts towards reaching priority populations; identify and connect with other community organisations and services already engaging with key audiences to deliver projects; extend geographical reach of all activities to ensure the benefits of projects are more equitable geographically; and consider how strategies can be linked across projects to share resources available with engaged audiences. The HEA highlighted that there are substantial opportunities to strengthen the equity focus of Kidsafe's strategies and increase its potential contribution to reducing falls injuries to Taranaki children who are most at risk of experiencing a serious injury.

CASE STUDY 4 - Community Oral Health Services for Children Under Five

In 2018, the Taranaki PHU undertook a HEA to prepare an evidence base for understanding inequities in engagement in the Community Oral Health Service (COHS) for children under five in Taranaki. The findings of the HEA were to be used to support the Oral Health Project Group (led by Te Pā Harakeke Māori Health Team) to identify opportunities for service improvements, with the aim of eliminating disparities in engagement in the COHS for tamariki aged 0-4 years and their whānau. Evidence was prepared from analysis of existing data, rapid literature review, nine key informant interviews, and existing data from interviews conducted with consumers in 2015.

Data analysis showed that tamariki Māori aged less than five years of age were 2.5 times more likely to be recorded as 'inactive' on the community oral health database than Non-Māori. The data also indicated an under-enrolment of tamariki Māori in the COHS compared to Non-Māori. Māori children aged less than five years of age had a 'Did not attend' (DNA) rate of 25%, compared to 11% for Non-Māori. Socio-economic inequities were also identified; the data showed children living in areas of high deprivation were more likely to have high DNA rates. Geographic inequities were highlighted for rurally isolated communities who experience engagement barriers, such as a lack of transport and longer travel distances. Non-Māori and high socio-economic families were viewed as advantaged in the COHS, with Non-Māori tending to be over-enrolled at 103%.

To address inequities in engagement in the COHS, the HEA called for a comprehensive approach that includes a range of strategies at multiple levels, including:

- *proximal/individual level* (eg. caregiver knowledge, awareness),
- *intermediate/community level* (community relationships, service integration) and
- *distal/macro level* (eg. service design, availability of services, transportation).

Standalone strategies that do not take into account the complex nature of the underlying causes of inequities within the oral health service system will not be effective at creating long-term change. A comprehensive 'systems approach' that includes a range of strategies at multiple levels and responds to the complex nature of inequities in the COHS is required.

CASE STUDY 5 - Breast Screening Participation in Taranaki

In 2019, the Taranaki PHU led a HEA of breast screening participation in Taranaki. It sought to understand the existing inequities in participation in breast screening in Taranaki, and highlight areas for potential intervention to improve equity in breast screening for wāhine Māori in Taranaki. The voices of local Taranaki breast screening service consumers were collected through face-to-face interviews with wāhine Māori and key informant interviews were conducted with breast screening service staff. A rapid literature review examined published research on barriers and enablers associated with participation of wāhine Māori in breast screening services, and provided an evidence base for the HEA. Finally, a stakeholder workshop was held to prioritise recommended actions.

The assessment report stated that all Taranaki women should benefit from breast screening regardless of who they are and where they live. As part of the human right to health, inequities in accessing the benefits of breast cancer screening programmes should be considered unfair and avoidable and, as such, warrant an active response. This HEA highlighted significant existing inequities in breast screening participation in Taranaki for wāhine Māori. It also drew attention to the socio-economic and geographic inequities wāhine Māori experience.

Taranaki breast screening services were found to advantage Non-Māori, particularly those who identify as New Zealand European. Wāhine Māori face much greater barriers to participation due to the impact of racism (especially past bad experiences with health services) and socio-economic deprivation, and being more likely to live in rural areas which are further away from breast screening services. The HEA identified factors contributing to inequities for wāhine Māori that are outside of the control of breast screening services, as well as intervention points where breast screening services can make positive changes to promote equity for Māori. The report called for a planned, comprehensive and collaborative system approach to address the persistent inequities regarding participation rates between Māori and Non-Māori in breast screening.

CASE STUDY 6 - Lead Maternity Carer (LMC) Registrations in First Trimester of Pregnancy

In 2019, the Taranaki PHU led a HEA of Lead Maternity Carer (LMC) registrations in the first trimester in Taranaki. It sought to understand the existing inequities in first trimester registrations with an LMC in Taranaki, and highlight areas for potential intervention to improve equity in LMC registrations in Taranaki. The HEAT tool was applied using a participatory approach at a wāhine Māori stakeholder hui held at a marae. Additional hui were held with Māori providers, and local data on registrations with LMCs was analysed. Consumer voice input was collected through face-to-face interviews with wāhine Māori about their experience of registering with an LMC.

This HEA highlighted existing inequities in registering with an LMC in the first trimester of pregnancy based on age, ethnicity, socio-economic status and geographical location (NZ Deprivation quintiles). It found that wāhine Māori in Taranaki experience a lower rate of registration with an LMC in the first trimester of pregnancy across all age groups, compared

to Non-Māori. This was particularly apparent for younger age groups. Māori were also more likely to live in an area of high deprivation compared to Non-Māori, which was another key factor impacting on lower rates of registration with an LMC within the first trimester.

A strong theme to emerge from this assessment was that, in Taranaki, Māori women were unlikely to get a midwife who understood their cultural needs around pregnancy and birthing. From the consumer voice, it was evident that the majority of wāhine Māori interviewed in this study would have preferred a Māori LMC who understood Te Ao Māori, but the reality was they had to accept a Non-Māori LMC. Key themes were the need for broader representation of Māori in the LMC workforce, improved cultural competencies of midwives through marae-based training, more Te Reo Māori in resources to support women to find a midwife, integrating midwife services with a Māori Health Provider and establishing kaiawhina roles to support women to register with an LMC.

Results Across Case Studies

HEA objectives

All of the HEA case studies shared common objectives; to apply a health equity planning lens to existing delivery of health services and programmes in order to (1) gain a deeper understanding of existing inequities and (2) identify potential areas for intervention to promote health equity. In addition, two HEA reports stated that they aimed to assess the likely impact current delivery is having on health inequities. These HEA were the first completed and were both undertaken on health promotion strategies, as opposed to health services.

Health issues assessed

The HEAT Tool was applied to six public health issues relating to child and women's health. Almost all assessments focused on aspects of child health (breastfeeding, child injury prevention, community oral health services, immunisation and maternity care) while half related to women's health (breast screening, maternity care and breastfeeding). Four HEA were undertaken on health services and two on health promotion programmes. Although background is not provided in all of the reports on how the HEA came about, it is noted that all except one HEA (Kidsafe) were either included in DHB/PHU annual plans submitted to the MOH or requested by the Taranaki DHB Chief Advisor, Māori Health. Each report indicated an intention to utilise the findings to inform future planning.

Sources of evidence

To inform the health equity analysis, Taranaki DHB developed an approach to applying the HEAT tool, evident across all six case studies (Figure One).

TARANAKI DHB
**Health Equity Assessment
 Sources of Evidence**



Figure One: Taranaki DHB Health Equity Assessment Sources of Evidence, 2019

The process draws on multiple sources of evidence (both qualitative and quantitative data sources) including data analysis, health consumer voice, stakeholder participation and rapid literature review to answer the HEAT tool questions. To complete the HEA, ten steps are followed in the Taranaki DHB HEA Process: identify, scope, commit, plan, collect evidence, analyse, report, share, implement and monitor and evaluate (Figure Two).

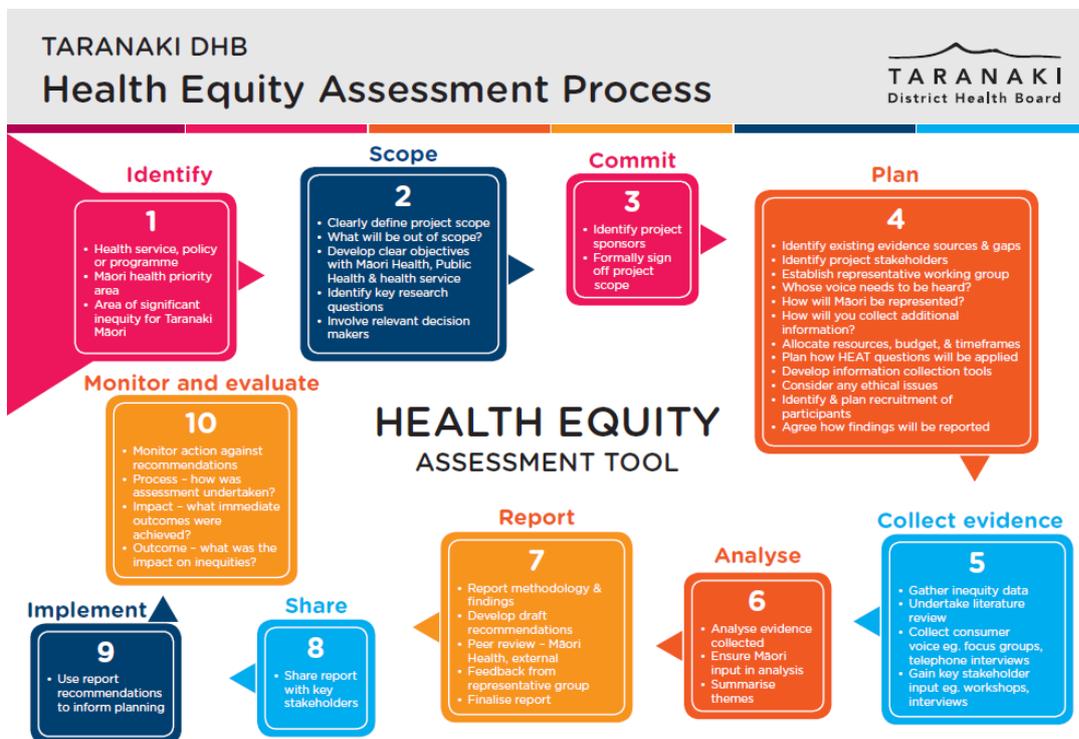


Figure Two: Taranaki DHB Health Equity Assessment Process, 2019

All HEA case studies included quantitative data analysis to identify inequities for sub-population groups, where possible (by ethnicity, geographic location, age and socio-economic deprivation). Gender data was analysed for two of the HEA.

Internal DHB and external stakeholders participated in each of the HEA, with Māori consumer voice collected in all but one HEA through face-to-face interviews, focus groups and telephone interviews.

Existing published literature was included in each of the reports, with four HEA including rapid literature reviews and two drawing on published literature throughout the reports.

All HEA utilised the HEAT Tool to guide the analysis, although some of the language in the 10 HEAT Tool questions was adapted accordingly. Four of the six case studies utilised the templates provided in the HEAT Tool user's guide.

Each HEA produced a final summary report with equity-focused recommendations for future planning. Due to the length of the reports, four of the HEA also produced brief executive summary reports.

Populations affected by inequities

The most prevalent inequities reported in the HEA were ethnic, geographic and socio-economic, which were identified in every case study. Each HEA highlighted inequities for Māori populations and one case drew attention to inequities for migrant populations. People living in higher deprivation, in South Taranaki, rural areas, and greater geographical distances from health services were commonly identified as experiencing inequities in the HEAs. Reports consistently recognised the intersecting nature of inequities across ethnic, geographic and socio-economic factors.

While age was considered in some of the HEAs, only two cases appeared to focus on age as an area of inequity (younger mothers). It is noted that three of the HEA focused explicitly on health issues related to children aged zero to five years old.

Equity analysis was undertaken by gender for one HEA, though it is noted that three of the six health areas assessed related exclusively to women's health.

Consideration was given to inequities relating to disability across three of the HEA. However, disability inequity was not highlighted as a key issue in any of the HEA, most likely due to a lack of data available.

Inequities relating to population factors beyond those listed in the HEAT Tool user's guide, such as sexuality and religion, were not considered in any of the HEA case studies.

Advantaged population groups

The six case studies commonly identified Pākehā, high socio-economic groups and people living close to health services, particularly those residing in New Plymouth, as the populations most advantaged in health service and programme delivery. Across all HEA case studies Non-Māori, specifically New Zealand Pākehā, were viewed as advantaged. The way in which health services and programmes are delivered was consistently viewed as most culturally appropriate for Pākehā, based on mono-cultural, Western, bio-medical understandings of health. Delivery of health services by a predominantly Non-Māori/Pākehā workforce was commonly highlighted. Pākehā were reported to be more likely to engage with health services, feel more comfortable doing so and less likely to experience racism in their experiences in the health system. Pākehā were also described as having preferential access to the determinants of health including education, employment, income, housing, health literacy and deprivation. Other mechanisms of advantage identified for Pākehā were preferential access to healthcare, faster pathways to health care, higher hospitalisation rates, and benefitting from health care configuration that advantages those with access to transport and other resources to attend appointments.

Higher socio-economic population groups were regarded as advantaged in all of the case studies, due to having greater financial resources to enable access to public health services and programmes; being more likely to be employed with good incomes, and in working arrangements with fewer challenges to attending appointments; living in wealthier areas with less deprivation; having access to their own transport; being more highly educated with higher literacy; placing greater value on preventative health and engagement with services; and having a better ability to pay for private health care.

Geographic populations residing closer to health services, particularly those living in New Plymouth, were identified as advantaged groups in all case studies. Closer proximity to permanent health services was viewed as enabling greater access for these groups, for example accessing general practices can be easier if there is one within walking distance for groups without transport. In addition, groups who had previous participation in health services with positive experiences and relationships, and supportive family networks were viewed as advantaged.

Drivers of inequities

Socio-economic disadvantage

All of the HEA case studies identified socio-economic disadvantage as a key contributor to health inequities. Factors such as living in poverty and being more likely to have lower education levels, resulting in higher health literacy demands, were commonly highlighted as key equity considerations. Socio-economic deprivation relating to housing was frequently cited as contributing to unfair health outcomes, most commonly in relation to poor quality of housing and being more likely to live in rental properties and associated transiency. More transient groups were highlighted as 'slipping through the gaps' of the health system due to regular changes of home address.

The intersecting nature of socio-economic disadvantage with living in more affordable rural areas and identifying as Māori was commonly noted in the reports. A key socio-economic consideration highlighted across the HEA was the significant financial pressures on low income groups that results in a number of more immediate life stresses (such as being time poor, having existing financial debts, difficulty paying for basic everyday needs and additional social problems) and results in health not being a high priority. Working conditions for people on low incomes were commonly identified as a contributor to inequities due to difficulty accessing flexible time off work to attend appointments.

Lack of cultural safety

All HEA highlighted a lack of culturally safe practice to appropriately meet the needs of Māori. Delivery was commonly described as culturally inappropriate, with staff delivering services lacking adequate awareness and understanding of the cultural needs of Māori populations. Māori consumers participating in the HEA commonly drew attention to the cultural disconnect they experienced when engaging with health services.

Western, bio-medical health model

All HEA drew attention to inequities in health resulting from a health system that is designed to meet the needs of Non-Māori, particularly Pākehā populations, by being based on a Western, bio-medical model of health. The Western-based medical model of health was commonly recognised as being culturally inappropriate for Māori, particularly the compartmentalising of health issues, in contrast to a holistic approach to hauora in Te Ao Māori. The mono-cultural design of well-meaning services and programmes was reported to increase inequities by benefitting Non-Māori groups, while failing to adequately meet the needs of Māori. Māori were reported as having few opportunities to input into how services and programmes were planned and whānau were not viewed as 'being at the centre of planning'.

Racism and discrimination

Racism within the health system was commonly highlighted in the HEAs. Fear, by Māori, of racially discriminatory treatment towards Māori was frequently reported, with negative past experiences and mistrust of health service staff and the broader health system commonly cited. Associated fear and anxiety with engaging with health services due to discriminatory practices was reported in two of the HEA. Racism was described as institutionalised in the health system, resulting in a lack of confidence amongst Māori in the quality of care they would receive.

Geographic disadvantage

Geographic barriers were emphasised in all HEA case studies, commonly highlighting the disadvantage experienced by populations living greater distances from health services, particularly those living in South Taranaki and more rural areas. The concentration of health services in New Plymouth was frequently cited as an equity issue due to differential access to health care. Māori were reported as being more likely to live further away from health services. The location of health services was viewed as an important equity consideration in

the HEAs, and mobile services that did reach geographically remote areas were thought to service these groups better. Fewer or no services available, such as a lack of general practices and 'after hours' doctors, was a common example of geographic disadvantage. The intersecting nature between socio-economic and geographic disadvantage were commonly referred to as compounding equity issues.

Transport barriers

Each HEA drew attention to transport barriers experienced by health consumers, with particular emphasis given to the practical barrier a lack of transport presents for lower socio-economic groups. The cost of travel was considered an additional disadvantage for people living further away from services. The costs associated with travel included having access to a private vehicle and financial means to cover the costs of the vehicle warrant of fitness, registration and petrol; lack of access to public transport and lack of money to afford the bus. The HEAs commonly viewed transport as a challenge to achieve equitable access to the benefits of health services and programmes.

Under representation of Māori in workforce

Two thirds of the HEA cases emphasised the lack of Māori staff delivering health services and suggested this contributes to a culturally inappropriate and incompetent health system for Māori consumers. Some of the HEA described the staff delivering services and programmes for Māori as not appropriate and suggested that Māori providers may be preferred by some consumers. One HEA highlighted the lack of choice for Māori consumers when selecting a health service provider if they do prefer to be cared for by a Māori health professional.

Lack of community and family networks

Two thirds of the HEA cases noted the barriers faced by groups who lack the appropriate supports to successfully access and engage with the health system. Groups who are not well connected to health and social services and community supports were considered to face additional barriers to participating in health services and programmes. Examples given were groups who had a lack of access to assistance to navigate the health system, lack of social connections and whānau support, and low engagement and existing relationships with services, such as general practices.

Lack of access to telephone

Two thirds of the HEA cases highlighted the practical barrier lower socio-economic groups' experience of accessing health services by telephone. A lack of credit on mobile phones was commonly reported as an access issue for lower income groups. A lack of internet was also noted in some HEA as a barrier to accessing information on health information and services.

Pathways for promoting equity

Thirteen pathways for promoting health equity were commonly identified across the HEA case studies.

1. *Equity focused planning*

All HEA cases recommended planning that prioritises achieving health equity. Health equity needs to be at the centre of routine planning and consideration given to how programmes and services are going to redress health inequities. The HEA noted that often inequities are complex and multi-faceted problems, and the equity response is not always within the scope of the health service or system under assessment, but applying HEAT offers an important opportunity to identify potential intervention points for promoting equity in planning.

Across all HEA, a range of strategies were found to be required at different levels in the system, suggesting equity focused planning takes a 'whole of systems' approach. Resources should be allocated to approaches that will meet the needs of the most disadvantaged groups. Therefore, if programmes and services cannot demonstrate a positive impact on inequities, action must be taken to divest from that programme or service or plan and action changes to specifically address inequities.

2. *Increase the Māori workforce*

A common recommendation across the HEAs was to increase the number of Māori staff working in health, and for 'by Māori, for Māori' approaches to promote equitable outcomes for Māori health consumers. Suggestions included supporting more Māori to enter the workforce through scholarships and cadetships, and more recruitment of Māori staff to work in the services.

3. *Cross sector collaboration and service integration*

A key strategy for promoting equity across the HEA was to undertake greater collaboration with other services and sectors. It was commonly noted that many of the opportunities for promoting health equity, particularly for Māori, will be achieved by working alongside other stakeholders, such as Māori community service providers, primary health organisations, general practices and early childhood centres. The oversight of programmes and services by multi-stakeholder governance groups with an explicit focus on health equity and adequate Māori representation was a suggested action to reduce inequities.

4. *Patient-centred services*

Attention was brought to the need to integrate services that have mutual audiences, such as children or women, to work together to meet the needs of service users and their whānau. This approach, it was noted, would enable health services to put patients at the centre of planning and could take a life-course approach to health services. The need for 'patient-centred' health services was highlighted in half of the HEA, an approach that can only be achieved by service integration and collaborations.

5. *Cultural safety*

A significant area requiring improvement across the HEA was a clear need for a more culturally competent health workforce and culturally safe practices. Building the capacity of existing staff to deliver services that are culturally safe for Māori was commonly highlighted to demand organisational attention. Consumer voice in the HEA consistently emphasised the

need for the people working within in the services who interface with the public to be more culturally safe in their practice. Recommendations included marae-based cultural responsiveness training, so as to develop staff skills, awareness and understanding of Te Ao Māori.

6. *Kaupapa Māori services*

The need for culturally appropriate delivery to meet the needs and aspirations of Māori was also a common recommendation across the HEA. Fundamental to addressing inequities for Māori is the provision of programmes and services that are culturally meaningful and appropriate for whānau. Recommendations commonly focused both on ensuring mainstream services were delivered in a way that better understands and responds to the needs of Māori, as well as recommending that Māori providers have a greater role in the delivery of kaupapa Māori services. HEA have consistently argued for service delivery partnerships with Māori health providers, additional resourcing of existing kaupapa Māori approaches, and for Māori health organisations to become providers of the services assessed in the HEAT case studies.

A commonly shared example of a programme which successfully addresses health inequities is the Hapu Wananga programme, a kaupapa Māori antenatal education programme. Hapu Wananga, by design, seeks to meet the needs of Māori individuals and whānau. The model, which includes delivery by Māori staff, at marae, incorporates tikanga Māori, integrates te reo Māori, involves whānau, is delivered free across Taranaki and has strong Māori participation, is a primary example of a health equity approach. The HEA collectively acknowledged that this kaupapa Māori model is the ideal vehicle for engaging Māori in health services and programmes.

7. *Additional resources in South Taranaki*

The majority of HEA recommended additional resourcing of services and programmes in South Taranaki. Promoting equitable access to the benefits of health services and programmes for people living in South Taranaki was championed in the HEA. Extending the reach of services to areas in South Taranaki (including Coastal Taranaki), as well as allocating additional resources to existing services and programmes, was proposed.

8. *Equity data reporting and monitoring*

A key HEA recommendation for planning to address health inequities is the continuous monitoring of inequity data. It was commonly suggested in the HEA that inequity data should be routinely reported by ethnicity, geographic location, age and socio-economic deprivation and that it is regularly reviewed, shared and drawn upon to inform planning. If this data is not easily available then advocacy is required to attain the data, an important health equity action in itself. Evaluation across the DHB should have an equity focus and contract performance reporting based on equity should be routinely undertaken.

9. *Use of Te Reo Māori*

The HEAs maintained that the use of Te Reo Māori should be integrated more strongly into health service and programme delivery. Consistently raised by consumers participating in the HEA, correct pronunciation and increased use is important to Māori and contributes to promoting health and wellbeing. The need for new resources that are bi-lingual and in te reo Māori was identified in two HEA. The use of Māori imagery, concepts of health and culturally relevant information was suggested.

10. *Addressing telephone barriers*

A practical HEA suggestion for achieving equitable access to health services and programmes was to address the barriers that low socio-economic groups regularly face when attempting to contact the health system. A lack of phone credit was a common contributing equity issue for low-income groups and it was suggested that health services ensure all groups can have free communication access. Suggested actions included promoting the 0800 numbers available more widely and establishing a free 0800 phone number for consumers to contact any health service in Taranaki from a mobile phone.

11. *Health promotion and communications*

The need for equity-focused targeted communications and health promotion was highlighted across a number of HEA reports. There were reported gaps in health promotion activities and planned wide-spread communications which highlighted opportunities for collaborative approaches. The need to undertake health promotion activities to reach Māori audiences through existing groups and events was commonly noted. Communication strategies were suggested in a number of HEA that have a specific equity emphasis, involve a range of stakeholders and incorporate a diverse range of communication forums, including social media.

12. *Community-based kaiawhina with transport support*

The important role of community-based kaiawhina to support Māori whānau to engage with health services was commonly reflected across the HEA. Appropriate, community-based support to assist whānau to navigate health services as suggested. This role was suggested for both child health services (such as community oral health), as well as for wāhine Māori (finding a midwife and breast screening). Importantly, the role of the kaiawhina was commonly linked to the provision of transport for health consumers. Other community-based roles were suggested in the HEA, such as nurse-led community health clinics and training community members to become health workers in the community.

13. *Consumer participation*

To ensure health services and programmes are meeting the needs of consumers, greater participation of consumers is required in planning. The HEA commonly emphasised the need to routinely collect feedback from health consumers, both those using the services and

those not engaging, to inform future planning. Collecting, sharing and reflecting on consumer feedback to inform future planning is an important equity focused approach that was found to be absent in the health areas assessed. Furthermore, opportunities exist for health services to gain greater participation of community in the review of existing and development of new programmes and services.

DISCUSSION

This paper provides a unique look at the collective findings from multiple HEA of Taranaki health services and programmes. A considerable strength of this paper is that each time the HEAT Tool was applied evidence was collected from a range of qualitative and quantitative data sources, including consumer voice, to inform the analysis, resulting in a relatively thorough examination of inequity across this body of work. The areas of health assessed were relatively alike, with their common focus on child and women's health services and programmes; as a result this paper may shed some light on the key equity considerations across child and maternal health care in Taranaki.

The most prevalent inequities reported in the HEA case studies were ethnic, geographic and socio-economic, which were identified in every case study. While these are the most significant areas of inequity, they are also the most visible, with unavailability of data relating to age and disability, for example, limiting the HEAT analysis.

Ethnic inequities

Each HEA highlighted inequities for Māori populations and subsequently focused on achieving health equity for Māori through out the assessment.

Pākehā, high socio-economic groups and people living close to health services, particularly those residing in New Plymouth, were commonly highlighted as the populations most advantaged in health service and programme delivery. However, the major structural advantage exposed by the case studies in this paper was how systematically health services and programmes are delivered in a way that meet the cultural needs of Pākehā and fail to meet the needs of Māori. The assessments drew attention to the necessity to offer an alternative to current mainstream health services (which are based on mono-cultural, Western, bio-medical understandings of health), if Māori are ever to benefit equitably. To do this, Māori need to play a lead role in the planning and delivery of services.

A key finding across the HEA was the consistent lack of cultural responsiveness of health services and programme staff to appropriately meet the needs of Māori, a point further punctuated by the fears of racism, negative past experiences and mistrust of staff, as well as the wider health system shared by Māori HEA participants. This finding is supported by the report recently released by the Waitangi Tribunal which states that there is evidence of institutionalised racism in the New Zealand health system and that the system fails to meet

its obligations under Te Tiriti o Waitangi to meet the needs and aspirations of Māori (Waitangi Tribunal, 2019).

Two thirds of the HEA cases emphasised the lack of Māori staff delivering health services and suggested this contributes to a culturally inappropriate and incompetent health system for Māori consumers. The important role that community based kaiawhina provide was highlighted in the HEA as a pathway for promoting equitable participation in health services for Māori.

Socio-economic & geographic inequities

All HEA identified socio-economic disadvantage as a key contributor to health inequities within the area under assessment. Inequities experienced by people living in higher deprivation and in South Taranaki, rural areas and greater geographical distances from health services were commonly emphasised, with HEAs consistently recognising the intersecting nature of inequities across socio-economic, geographic and ethnic factors.

Two thirds of the HEA cases noted the barriers faced by groups who lack the appropriate supports to successfully access and engage with the health system, suggesting that social isolation and breakdown of family structures can put health consumers at significant disadvantage to accessing the care they need, an issue further compounded by geographic distance and socio-economic deprivation.

The lack of credit on mobile phones commonly reported as an access issue for lower income groups warrants careful consideration by the health sector on how to ensure telephone communication is not 'cut off' due to cost in the modern day reliance on mobile phones. Considering the access to mobile credit and data, as well as internet, are emerging equity issues that health services need to increasingly take into consideration.

Each HEA drew attention to transport barriers experienced by health consumers.

DHB response to inequities identified in the HEA

To respond to what is clearly shown as wide-spread and persistent inequities for Māori, low socio-economic groups and people living in South Taranaki, consideration of health inequities is fundamentally essential in all routine health service and programme planning in Taranaki. The HEAT Tool can assist with applying a critical health lens and can enable health services to better understand the demand for an equity response, the underlying causes of inequities and identify 'how to act'.

Planning tools such as HEAT are only useful if they are applied and used to inform planning. While the Taranaki DHB has made a clear commitment that it will use the HEAT tool to promote equity in planning, stronger organisational policy is required regarding associated expectations (such as applying HEAT and implementing recommendations), a framework to clarify how this will be achieved in practice, and a strategy for building the capacity of its staff to undertake this work.

The lack of cultural responsiveness in the existing workforce, as well as the lack of Māori working in the DHB, were both found to be drivers of inequities, but also identified as potential entry points for promoting more equitable health services in Taranaki.

With only 9% of the Taranaki DHB workforce identifying as Māori, when Māori account for nearly 20% of the Taranaki population, this is a key equity concern. It is noted that the WhyOra workforce development programme is in place to grow the Māori workforce. However, it takes time to train health professionals, so there should be a strong emphasis on the existing workforce being responsive and appropriate for Māori. This paper argues that the area of Human Resources (HR) would benefit from being assessed with a health equity lens. Given the significant role 'people' have been found to have across these HEA, it is suggested that a HEA is conducted with the HR department to examine opportunities for promoting health equity for Māori in DHB HR policies, recruitment processes and staff competencies (cultural safety and te reo Māori).

As well as requiring greater resourcing for developing staff cultural safety practices, there is also significant work required to improve the workforce's use and pronunciation of te reo Māori for current health services to better meet the need of Māori populations. It is suggested that an organisational strategy to develop staff cultural safety practices and te reo Māori language skills within the organisation may be warranted. The commonly identified opportunities to use equity-focused health promotion and communications to better meet the needs of priority groups identified in the HEA indicates these are areas that require an equity-lens review.

Many of the pathways for promoting health equity that have been identified in this report are expressed in the kaupapa Māori antenatal education programme, Hapū Wānanga. The finding that one single health programme was consistently identified across all HEA case studies to promote equity for Māori is indicative of the potential of the 'Hapū Wānanga Model' to be replicated to drive equity efforts in Taranaki. It is argued that all of the drivers of inequities are appropriately responded to in this model, while many of the pathways are reflected in its design. It is suggested that the approach taken by the Taranaki DHB to implement Hapū Wānanga should act as an exemplar of how DHB services and programmes can appropriately meet the needs of Māori and promote equitable health outcomes for Taranaki populations.

Cross-sector collaboration

Commonly, a range of determinants of health were found to contribute to inequities, including transport, income and housing, many of which are outside of the control of the health sector. This reinforces the need for cross-sector collaboration.

The findings of this report reiterate the need for health services to be placing a critical health equity lens over themselves to detect how 'mainstream' services are acting to privilege some groups over others and to plan how to redress this.

CONCLUSION

Overall, the HEA conducted at Taranaki DHB have provided an evidence-based, strong impetus for change.

An example was use of the findings from HEA to disestablish the PHU Breastfeeding Welcome Here programme, which was clearly not meeting the needs of Māori and was doing little to reduce the inequities in breastfeeding rates between Māori and Non-Māori. The HEA supported the establishment of the kaupapa Māori antenatal programme, Hapū Wānanga, which has improved the reach of antenatal education to wāhine Māori, their partners and whānau. This is a shining example of a 'mainstream' health organisation applying a critical health equity lens and committing to equity-focused change, resulting in a dramatic change in practice and allocation of resourcing to advance Māori health outcomes.

While not all HEA have led to such positive change, clearly this can be done. Privileging the voice of those who have lived experience of health inequities in HEA is key to re-orientating health services to reduce inequities and better meet consumer need.

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