Module 1: Health equity in practice

Study Guide

Building health equity and cultural safety in Aotearoa / New Zealand

unepartnerships

Version M1.0

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Module covered by this Study Guide: Health equity in practice

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Contents

Record of consultation

This section details who UNEP has consulted in developing, updating, or revising the learning resources for this course.

Name[1]	Title Role	Date	Outcomes
Louise Hill	Consultant	Nov 2021	Consultation with key stakeholders to design course structure and high-level content. Write drafts for consultation.
Colleen Sullivan	Consultant	Oct 2021	Co-design course outline and objectives. Review drafts, provision of examples and ideas.
Michelle Te Kira	Chair PMAANZ	June – Sept 2021	Co-design course outline and objectives. Review drafts, provision of examples and ideas. Cultural appropriateness check of content.
Heidi Bubendorfer	Secretary PMAANZ	June – Sept 2021	Co-design course outline and objectives. Review drafts, provision of examples and ideas. Cultural appropriateness check of content.
Bethan Rajwer	Education PMAANZ	June – Sept 2021	Co-design course outline and objectives. Review drafts, provision of examples and ideas. Cultural appropriateness check of content.
Gary Smith	Academic Director, UNEP	August 2021	Review draft version 3, feedback provided and incorporated.

[1] Details of UNEP Representative who recorded the consultation, and Industry Representative who was consulted and outline in 20-50 words feedback, recommendations, and outcome of consultation.

Introduction

Welcome to Health equity in practice. This Module is tailored to practice managers and staff across the healthcare practice landscape, for example general practice, specialist practices, allied health, and dentistry. Practice managers are key stakeholders in the practice culture and leadership team, and have responsibility and influence in ensuring the practice is accessible and culturally safe for disadvantaged population groups. This Module supports staff in understanding health equity and how to achieve it for your community.

On completion of this Module, students will understand equity in healthcare, including the contributing factors and barriers to achieving equity in health outcomes for disadvantaged groups. Students will understand the strategic context of health equity, and will be introduced to specific tools to define, measure and implement effective strategies to support equity in your practice.

Outcomes

On completion of this Module, you will be able to:

- ✓ Understand equity, and how inequity contributes to different health outcomes for different population groups
- ✓ Understand implicit bias and be able to reflect on your implicit biases
- ✓ Understand the importance of good quality data to analyse and inform equity initiatives in your practice
- ✓ Understand how leadership improves health equity for your community.

Structure

This course is divided into the following Lessons:

- Lesson 1: Understanding equity
- Lesson 2: Understanding and managing bias
- Lesson 3: Equity: The big picture
- Lesson 4: Using data to achieve equity
- Lesson 5: Leadership to achieve equity.

Activities

Throughout this Study Guide you will notice a range of activities. These are intended to contribute to your learning by encouraging you to be active and involved. None are compulsory. They are intended to help you to learn but are not part of your formal assessment.

Activities with an online interactive version are identified with a mouse icon at the start.

Common activity types included in study guides are included below.

- Knowledge check or Reflection: These encourage you to confirm or explore your understanding as you progress.
- Reading: These may be uploaded to my.unep or provided as links to readings or websites to expand on the content of the Lesson .
- Video or Link: These provide alternative perspectives and give visual and audio alternatives to your text. Please do not feel you are required to watch all videos or read through all the links provided in this Study Guide.
- Find out more: In some Lesson s we provide support for additional reading or activities that go beyond what is required in the unit covered in this course or provide a refresher for underpinning concepts that support the knowledge and skills for this unit.
- Case study or Example: There are a range of case studies and examples provided throughout this Study Guide, to support your understanding and to provide a resource for some activities.

The end of an activity is identified with a band, like the one below and the text 'End of activity'. This indicates the normal Study Guide text will resume.

End of activity

Common Terms: You will notice that throughout this Study Guide we use the term 'patients' to refer to the people your team provides services or support to. In your workplace, you might use other terms such as patient, client, staff, employees, volunteers, or stakeholders.

We use the term 'medical receptionist' or receptionist to refer to the administrative staff in your team. In your workplace, you might use the term secretary, front desk staff, administrative assistant, or another term. Additionally, you may be a receptionist in a different type of practice, such as general practice, specialist practice, allied health, psychology, or mixed practice.

We use the term 'practitioner' to refer to the clinical team working in the healthcare practice. This could include general practitioners, specialists, allied health practitioners, psychologists, or other health professionals working within or referring to your practice.

Lesson 1: Understanding equity

Equity, equality, and diversity are terms commonly used in healthcare today. While the ambition of 'equal access for all' can be conceptually understood as the right thing to do, it can be difficult to measure, implement and evaluate at a practice level because you are measuring the people who are not attending your practice, but who should be. As a practice manager, it is important to understand equity and the barriers to equal health outcomes, including those outside of your control. This Lesson introduces the concept of equity and the relevance to practice managers.

1.1 Defining equity

Some people face greater barriers than others to experiencing a healthy life. Although both life expectancy and *healthy* life expectancy have increased globally, life expectancy is unequal between the rich and poor. There is a persistent and sometimes widening gap between those with the best and worst health and well-being. This is occurring not just in poor countries, but within rich countries such as Aotearoa / New Zealand (NZ) and Australia.

So, what is health equity, and how is it measured? The NZ Ministry of Health uses the following definition:

Health equity: In NZ, people have differences in health that are not only unfair and unjust but avoidable. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes[2].

The graphic below illustrates the difference between equality and equity. To achieve equity in health outcomes, we must first ensure everyone has the basics needed to be healthy. Thinking the same approach to health will work universally, is like expecting everyone to be able to ride the same bike. In this analogy, everyone getting the same bike will lead to different outcomes for different groups of people. Likewise, a one-size-fits-all approach to healthcare results in different health outcomes for different groups of people, because the healthcare provided may not be suitable for all of the different population groups.

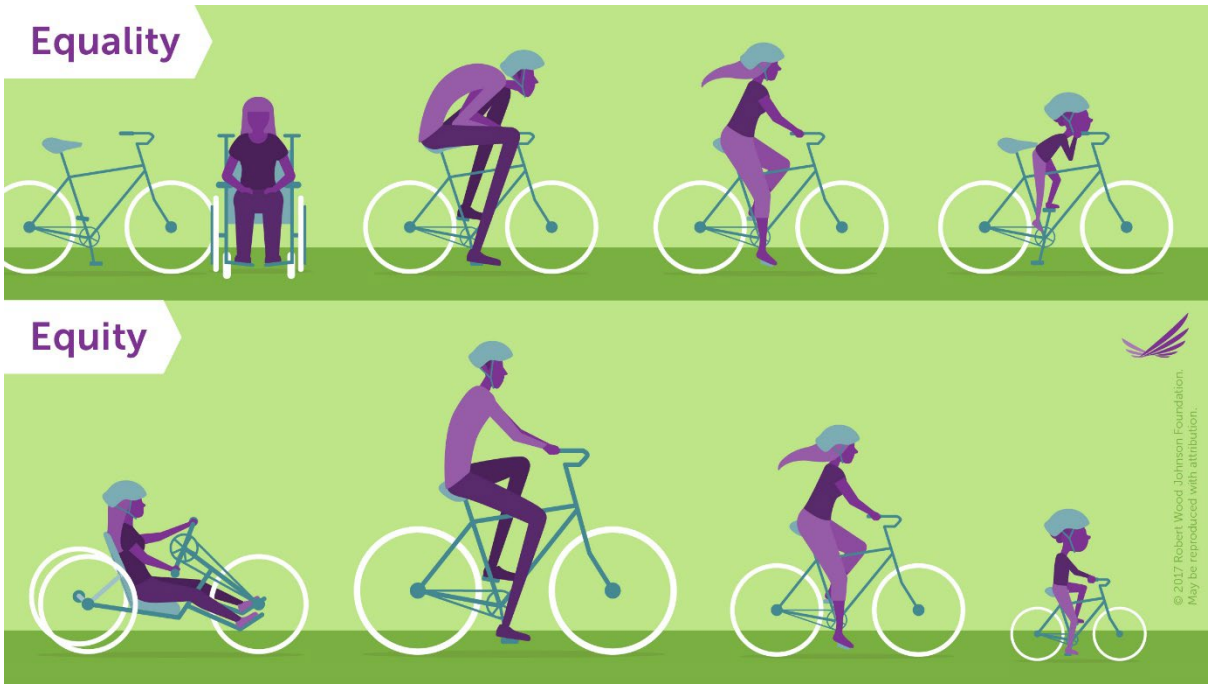


Figure 1: Equality and equity[3]

Equality involves everyone getting the same resources, even though one group may need more or different resources, such as information in a different language, a different (culturally safe) approach, or physically different resources such as wheelchair accessibility. Equity, on the other hand, requires

[2] Ministry of Health, 2021. *Achieving equity*, URL: https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity Retrieved 1 November 2021

[3] Robert Wood Johnson Foundation, 2017. *Visualizing Health Equity: One Size Does Not Fit All Infographic*, URL: https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html Retrieved 1 November 2021

more, and possibly different, resources to support disadvantaged groups to ensure everyone has access to the basic requirements that are needed to be healthy. Imagine that you manage the following practices:

- Practice 1: a practice in a middle-class city suburb with predominantly well-off people who have good jobs and a high level of education.
- Practice 2: a practice that is in a rural, low-income area where people have a lower level of health literacy, and it is difficult to recruit and retain staff.

Would these two practices be able to fairly serve their communities with the same resources and the same approach? Probably not. Instead of sharing resources equally, those practices need a different portion of the available resources and a targeted approach to fairly serve their communities. This is equity.

Who is disadvantaged?

Poorer populations systematically experience worse health than richer populations[4]. The make-up of disadvantaged, poorer population groups will differ in different countries, and within different geographical areas of a country. Consider the following contextual differences that could influence the health outcomes for different groups of people.

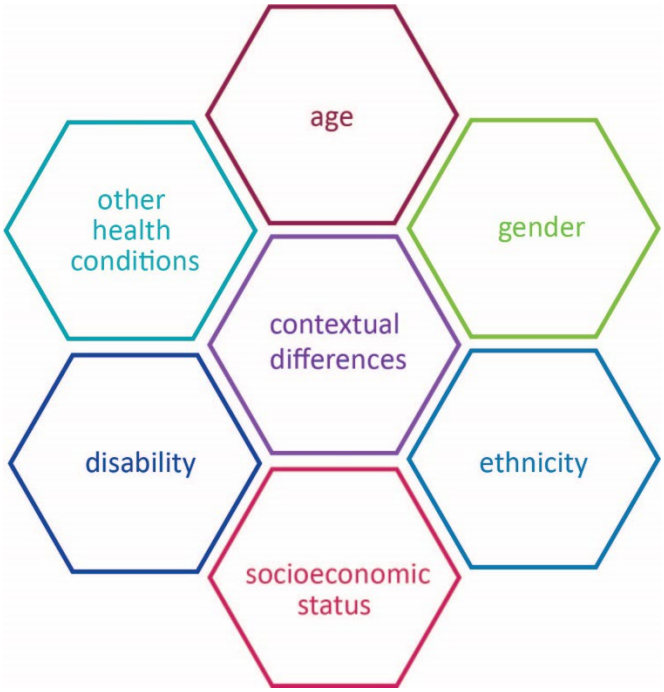


Figure 2: Influences on health outcomes

To have a positive impact on equity, your practice needs to really understand:

1. the population groups with the greatest healthcare needs in your community
2. the disadvantaged groups that have barriers to accessing your practice.

[4] World Health Organisation, 2021. *Social determinants of health*, URL: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3 Retrieved 1 November 2021

These may be groups defined by any of the above contextual factors such as age, ethnicity, gender, or disability. To accurately define these groups, you need data. Some data will already be available in your practice, most likely through the practice management software. Other data will need to be collected. Once you have defined the problem and measured it using data, the practice is able to design a quality improvement initiative that targets the disadvantaged population groups. This concept will be further explored later in this Module.

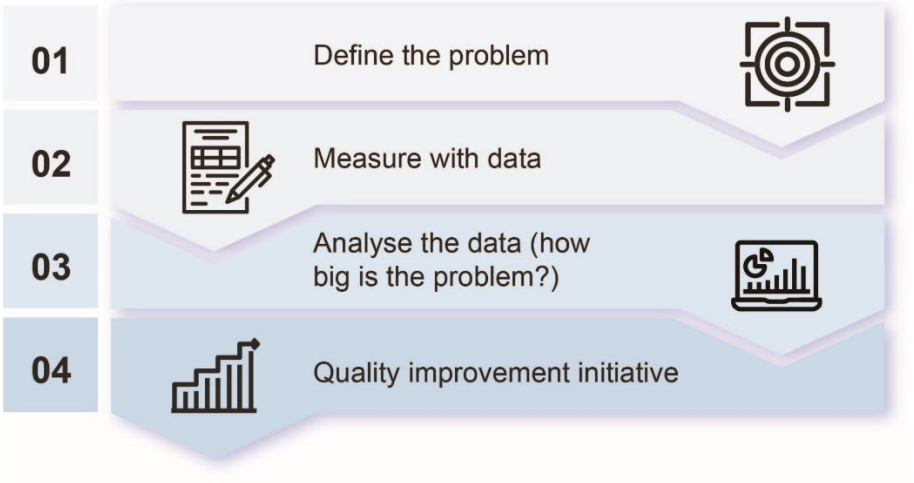


Figure 3: Defining the quality improvement initiative

The diagram above outlines the initial steps you take to define the quality improvement initiative required in your practice. This then forms part of quality improvement cycle, where the outcome is measured and continues to inform the quality improvement initiative as it evolves. If you are not familiar with quality improvement in a healthcare practice, the short course: Fundamentals of Practice Management covers this topic.

Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health.

Disadvantaged groups need more resources and a different approach.

We will now look more closely at the factors that influence health outcomes.

1.2 The social determinants of health

The social determinants of health are the non-medical factors that influence health outcomes for disadvantaged groups of people. They are the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include social, political, and economic policies and systems, as well as social norms and culture.

The social determinants of health significantly influence the health outcomes of population groups, with health and illness following the same trend in all countries. Often, the lower the socioeconomic position, the worse the health outcomes. As such, disadvantaged groups within the population, such as different ethnic groups, have overall worse health outcomes compared to advantaged sections of the population, as they tend to also have poorer access to education, job security, secure housing, and food security.

The World Health Organisation provides examples of the social determinants of health, which can influence health equity in positive and negative ways; these are set out in the diagram below.

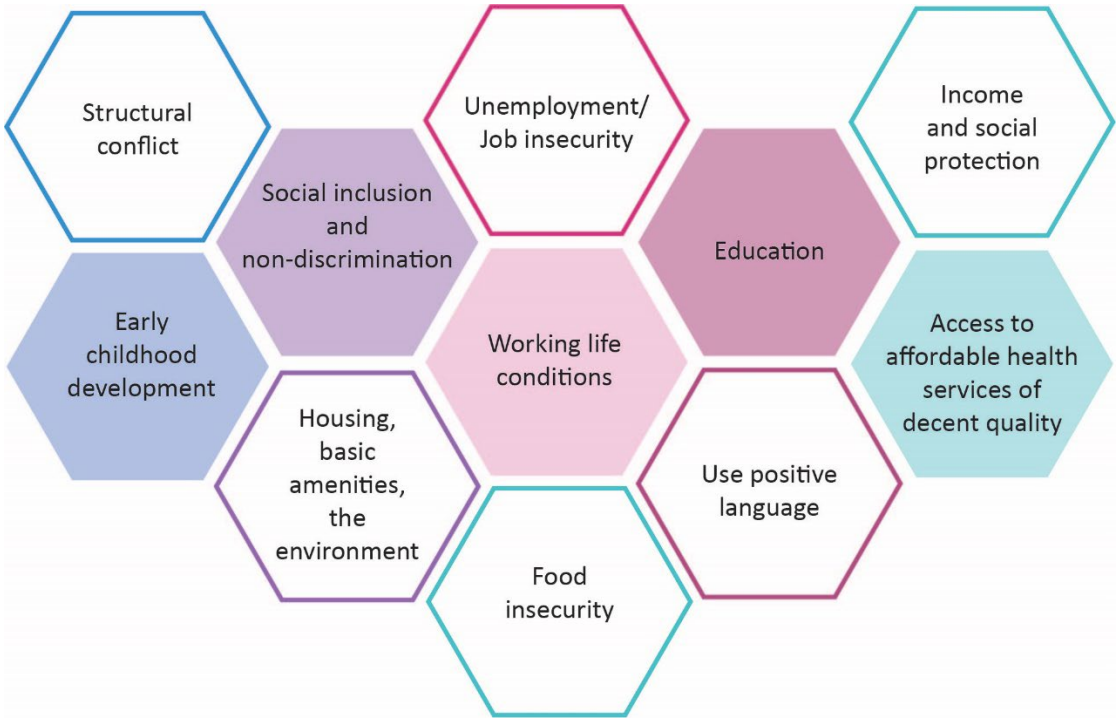


Figure 4:Social determinants of health

Research shows that the social determinants of health can have more influence over health outcomes than healthcare or lifestyle choices[5]. As such, the health system alone will not achieve health equity for disadvantaged groups, and governments and not-for-profits have a significant role in addressing the social determinants of health to achieve health equity for disadvantaged groups.

Activity 1: Case study – Māori health disparities

In NZ, Māori people have the worst health inequity of any group. Māori are sicker and die sooner than our Pākehā counterparts. We use Hone as a case study.

Hone was born into a Māori Whānau as the fifth of six children. Neither of his parents finished high school, and both parents worked full-time in low-income jobs. His father experienced periods of unemployment and had ongoing issues with alcohol addiction. Hone's extended family and community looked after the children when his parents worked.

Hone's family lived in a small home with his extended whānau and experienced overcrowding at home. Hone's grandparents provided much of his early childhood care. They had experienced discrimination in the health system in their past, and therefore were reluctant to access health services. As such, none of the children were vaccinated or received regular healthcare growing up.

[5] World Health Organisation, 2021. *Social determinants of health*, URL: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_3 Retrieved 1 November 2021

As an adult, Hone had difficulty accessing and engaging with health services due to a lack of experience, generational distrust due to discrimination, and poor health literacy. Hone has several risk factors for chronic disease and has general poor health, including smoking, excess alcohol consumption, obesity, and non-compliance with the medication he was prescribed for high blood pressure.

The health system is not providing Hone with equity of access to healthcare services, and therefore he is more likely to be sicker and to die sooner. He requires different resources, and a different approach.

End of activity

While changing key social determinants of health for your community may be outside your level of influence, it is important to understand why people from particular groups are disadvantaged. Everyone has a history that has shaped the way they engage with your practice and staff. Equally, every staff member has a history with experiences that have shaped the way they engage with disadvantaged groups. These experiences create bias, and bias is an important concept to understand when considering equity.

Summary

In NZ, people have differences in health that are not only avoidable but may be unfair and unjust. Equity recognises that people with different levels of advantage require different approaches and resources to get equitable health outcomes[6]. Disadvantaged groups could be identified by their ethnicity, age, gender, geographical location, sexuality, religion or other contextual factor.

Achieving equity in health outcomes is increasingly a priority for governments, with a focus on multifactorial government approaches. Multifactorial approaches are critical when you consider the complexities of the social determinants of health including housing, education, disability, food security, conflict and other factors. While a healthcare practice cannot change the social determinants of health for their population, the practice can support people from disadvantaged groups to access healthcare.

[6] Ministry of Health, 2021. *Achieving equity*, URL: https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity Retrieved 1 November 2021

Lesson 2: Understanding and managing bias

To provide a culturally safe healthcare environment that improves access and therefore equity in health outcomes, staff need to treat all individuals with dignity and respect. Everyone has different life experiences, and these life experiences create both conscious and unconscious thoughts and behaviours. These thoughts occur instantaneously and you may not be aware of them. This Lesson introduces the concept of bias, and how it naturally occurs to help your brain make sense of the information it receives.

People of ethnic groups—particularly high needs population communities, often experience high levels of disadvantage and health inequity. However, this Lesson is not specifically about race or ethnicity because implicit bias can occur towards any population group such as disability, age, gender, religion, geographically isolated, sexual orientation or identity. Rather, in this Lesson we focus on the concept of bias that can be applied to any disadvantaged population group, including Māori.

2.1 Understanding bias

Bias is classified as implicit (unconscious) or explicit (conscious).

Implicit bias: attitudes and beliefs that occur outside of our conscious awareness and control.

Explicit bias: biases we are aware of on a conscious level.

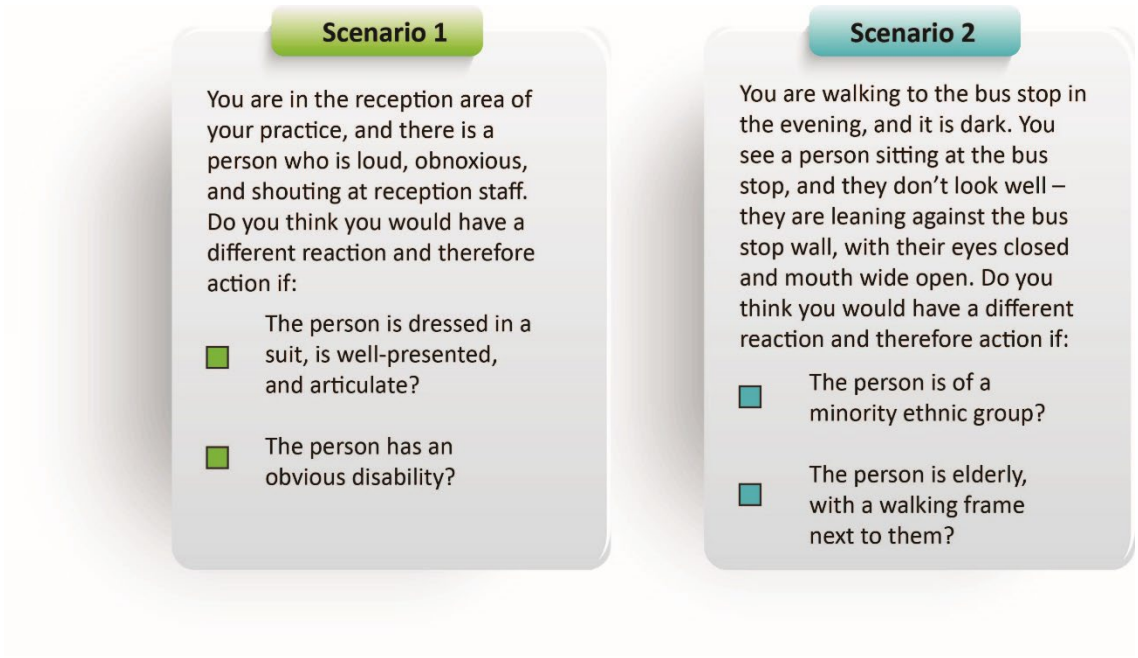
In this Module we focus on ***implicit bias*** because once you are aware of a bias and it is explicit (or it is in your conscious level), you can take steps to manage it differently. This is the first step towards change.

Implicit bias

Implicit bias is a natural way for the brain to instantaneously make sense of the huge quantity of information presented to it every moment. Without an internal prioritisation and filing system, we would be overwhelmed with too much information for our brain to process, resulting in the brain not processing information well or even at all. We therefore use stereotypes instantaneously and unconsciously to make sense of, and 'sort', the world.

Consider the following scenarios where internal bias may unconsciously provide you with a particular stereotype, and therefore influence your thoughts and actions.

Activity 2: Reflection – Stereotypes



End of activity

Unconscious stereotypes, such as implicit biases, are common. Individuals naturally have an affinity for people who are like themselves. The similar group could be related to ethnicity, age, gender or identity, and the group will change depending on the situation. Stereotypes exist in society, and we internalise the stereotypes without really being consciously aware of them. These distorted perceptions lead to behaviours that can cause discrimination, which in turn impact health outcomes for different groups of people.

Figure 5: Discrimination impact on health outcomes

Activity 3: Videos – Understanding bias

The following videos offer great information on understanding bias to complement your learning.

The Health Quality and Safety Commission of New Zealand (HQSCNZ) has created three videos in a series about bias. Watch videos 1 and 3 (video 2 is included as viewing in Module 2).

Video 1: Understanding and addressing implicit bias

The video provides examples of healthcare professionals reflecting on their own implicit bias, provides an explanation of implicit bias, and strategies for change.

- Understanding bias – Vimeo
- Understanding Bias

Video 3: Experiences of bias

In this video you will hear people talking about their experiences of bias in a health setting, and their suggestions for practical tips to ensure you don't make the same mistakes.

- Experiencing bias

End of activity

2.2 Self-reflection

As you now understand, implicit bias naturally occurs for the brain to sort and group a huge amount of information very quickly. As such, everyone has implicit biases. The very nature of implicit bias is that it is unconscious, meaning you are not aware of it. The following activity allows you to test yourself for implicit biases, as the first step towards change is awareness.

Activity 4: Self-reflection – Project implicit

Project Implicit allows you to take a free test to assess your implicit biases in areas such as disability, ethnicity, age and sexuality. It can be confronting but valuable to test yourself for implicit biases around the groups of people in your practice's community.

Completing this test(s) is for your own understanding and personal reflection only. There is no need to share your results.

- Project implicit

End of activity

Summary

To cope with the huge quantity of information the human brain is required to process every moment, we have an internal prioritisation and filing system that works instantaneously. We naturally use stereotypes to sort this information out and categorise it, unconsciously. This is implicit, or unconscious, bias.

Understanding your personal implicit bias requires you to reflect on your unconscious stereotypes. Shifting implicit bias to the conscious part of your brain is required as a step towards positive change.

Lesson 3: The equity context

Understanding and being committed to health equity is one thing; achieving it is quite another. Closing the gap on health outcomes (i.e., achieving equity) can be considered a 'wicked' problem in its size and complexity, requiring government and inter-organisational solutions to address the many social determinants of health.

However, if each practice and provider of health services aims to achieve health equity for their community, it is another step in the right direction. This Lesson provides background context on the government strategy in NZ, particularly in relation to equity in health outcomes for Māori.

It is important to understand how your practice fits within the big picture as there are legal and ethical obligations with which you must demonstrate compliance. These are explored further in Module 2.

3.1 The context

In NZ, there have been some notable successes in closing the gap between Māori and non-Māori health outcomes. One example is childhood vaccinations rates. Creation of a national health target has been successful in raising the overall proportion of age-appropriate fully immunised two-year-old children from 67% in 2007 to 93.5% in 2016[7,8]. As a result, longstanding ethnic inequity in immunisation rates has all but been eliminated.

There are, however, persistent gaps in the provision of health services and health outcomes between Māori and non-Māori, and other advantaged / disadvantaged groups. The Health Quality and Safety Commission (HQSC) of NZ [9] describes some of these inequities, including:

- Amenable mortality for Māori and Pacific peoples aged 0–74 years is twice that of 'other' ethnic groups.
- People living in deprived areas are 1.5 times more likely to report unmet need for primary healthcare than those living in non-deprived areas.
- Women were dispensed 26 percent more strong opioids than men.
- Māori consumers are consistently and significantly less likely to always feel staff treated them with respect and dignity while they were in the hospital.
- A maternal mortality rate for Māori that is nearly three time(s) that of New Zealand Europeans.
- There is an inequitable burden of sudden unexplained death in infancy (SUDI) for Māori and Pacific infants, and infants of young mothers.
- For people with rectal cancer, there was wide geographical variation in the use of short course radiotherapy in public hospitals.

To ensure sustained attention is provided to practices to address inequity, Primary Health Organisations (PHO's) provide health targets and data to practices. The data needs to be captured and produced by the Practice Management Software (PMS) and is vital in setting the practices clinical targets and reducing inequalities.

3.2 High level strategy

When you understand how the social determinants of health contribute to inequity in health outcomes, it can be easy to feel overwhelmed and ineffective by such a wicked problem. Government has a key role in creating health equity by addressing social determinants of health across different departments. It is important to understand the strategies and action plans of your government because the policies will influence how your practice needs to act, including incentives for funding, restructures of service providers, and to ensure your practice meets its compliance obligations.

The following documents are important reading.

[7] Ministry of Health, 2016. *Annual Report for the Year Ended 30 June 2016*, Ministry of Health, Wellington, NZ
[8] Health Quality & Safety Commission, 2016. *Health quality and safety indicators*, Wellington, NZ
[9] Poynter, M., et al, 2017. *Quality improvement: no quality without equity*, [pdf], URL: https://www.hqsc.govt.nz/assets/Other-Topics/Equity/Quality_improvement_-_no_quality_without_equity.pdf Retrieved 1 November 2021

He Korowai Oranga

As NZ's Māori Health Strategy, He Korowai Oranga sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori.

The He Korowai Oranga framework is a living, web-based document outlining the components of the framework in an interactive pyramid.

Implementing He Korowai Oranga is the responsibility of the whole of the health and disability sector, including your practice.

Activity 5: Reading – He Korowai Oranga

Ensure you have a good understanding of the framework by exploring the interactive pyramid found here:

- He Korowai Oranga

Reflect on which components of the He Korowai Oranga framework you relate to most strongly. They may be components you have seen change during your career, or your practice does well, or perhaps you have personal experience to draw from. List your top three components here.

Now reflect on which components of the He Korowai Oranga framework you find most foreign. These could be opportunities to upskill yourself, your practice staff, or to implement a quality improvement project. Write down your top three components here.

End of activity

Whakamaua: Māori Health Action Plan 2020–2025

Whakamaua: Māori Health Action Plan 2020-2025 is the implementation plan for He Korowai Oranga. It sets the government's direction for Māori health advancement over the next five years, thereby helping to achieve better health outcomes for Māori.

Whakamaua is underpinned by the Ministry's Te Tiriti o Waitangi Framework, which provides a tool for the health and disability system to fulfil its stewardship obligations and special relationship between Māori and the Crown.

Whakamaua outlines a suite of actions that will help to achieve four high-level outcomes. These are:

- Iwi, Hapū, Whānau and Māori communities exercising their authority to improve their health and wellbeing
- ensuring the health and disability system is fair and sustainable and delivers more equitable outcomes for Māori
- addressing racism and discrimination in all its forms
- protecting Mātauranga Māori throughout the health and disability system.

Activity 6: Reading – Whakamaua: Māori Health Action Plan 2020–2025

Read more about Whakamaua here:

- Whakamaua mental health action plan

End of activity

Te Tiriti o Waitangi

Te Tiriti o Waitangi is explored in more detail in *Module 2: Cultural Safety*. However, it is important to understand the link between Te Tiriti o Waitangi, He Korowai Oranga, and Whakamaua: Māori Health Action Plan 2020-2025.

Activity 7: Reading – Te Tiriti o Waitangi framework

Review the following graphics developed by the Ministry of Health, to further your understanding of the Te Tiriti o Waitangi framework.

- Te Tiriti o Waitangi framework

End of activity

Summary

It is important to understand the strategic context and government priorities that impact the healthcare sector. In NZ, people working in the healthcare system need to have read and understood the following government documents:

1. NZ ’s Māori Health Strategy, *He Korowai Oranga*, which sets the overarching framework that guides the government and the health and disability sector to achieve the best health outcomes for Māori.
2. *Whakamaua: Māori Health Action Plan 2020-2025* is the implementation plan for He Korowai Oranga. It sets the government’s direction for Māori health advancement over the next five years, thereby helping to achieve better health outcomes for Māori.
3. *Te Tiriti o Waitangi*

Module 2 covers the obligations and implications of government strategy on practice managers.

Lesson 4: Using data to achieve equity

Over the past few decades, health has shifted to a data-driven environment. The systemisation of practices has allowed data to be collected and used to identify opportunities for quality improvement, including identifying cohorts of patients and targeting care towards them. For example, in the COVID-19 environment, patients of a particular demographic were identified and targeted for priority vaccination; using information technology and data to inform equity in your practice is no different. This Lesson provides guidance on how to collect and use data to drive equity in your practice.

4.1 Data and audit

In the contemporary healthcare environment, data drives the provision of safe and quality healthcare. Data is used to identify opportunities for improvement, and then evaluate the effectiveness of the quality improvement projects. Government funding is increasingly linked to data, to the point that government uses data to incentivise practices in the government's priority areas such as equity.

Data is grouped into two categories, as explained below.

Table 1: Qualitative vs quantitative data

	Qualitative	Quantitative
Definition	Measures, types e.g., categories	Numeric variables e.g., how much, how many, how often
Examples	Ethnic self-identification Gender Age Postcode (geographic location) e.g., rural vs metropolitan Financial status (e.g., pension card)	% of patients who have received X health check % of Māori patients who are prescribed medication Y Infant mortality rate

As the practice manager, it is important that you understand the capabilities of your software systems, as the system will have data available for analysis if you know how to access it. But remember, the data output is only as good as the input, meaning that if patient information is incomplete, your data set will be incomplete. Train your staff on why it is important to enter the data correctly and completely into the system.

Qualitative and quantitative data is necessary to identify:

- existing inequalities
- effective interventions
- evaluation of interventions.

Figure 6:Use of data

If you do not have sufficient data to identify inequities in access or health outcomes, you may need to discuss with your practice team to see if there is existing data you can access and analyse, or a way to introduce new sources of data collection to analyse in the future. Perhaps your reception staff have not prioritised collecting and entering ethnicity because they don't understand how the data is used or the clinical outcomes that result from collection of this data. Education and support of reception staff to start collecting and / or entering accurate information may be necessary.

4.2 Ethnicity data

Ethnicity refers to a group of people who have the same cultural, national, or racial origins and can be the ethnic group or groups that individuals identify with or to whom they feel that they belong.

Ethnicity data is one form of demographic data that is used to inform service planning and quality improvement initiatives. Closing the gap in health outcomes for disadvantaged cultural groups, such as high needs population people, are a high priority for governments including those in NZ, Australia and Canada. While each government has different strategies, there is learning from international experience that should be shared.

The purpose of collecting ethnicity data includes:

- measuring and monitoring population health over time, which identifies which ethnic groups have inequity in health outcomes
- targeting funding and allocation of resources to the ethnic groups who experience inequity
- guiding clinicians on the implementation of individual care plans and interventions.

Figure 7: Purpose of collecting ethnicity data

The following activity introduces the Primary Care Ethnicity Data Audit Toolkit, which is a best practice audit tool in NZ.

Activity 8: Reading – Primary care ethnicity data audit toolkit

The Primary Care Ethnicity Data Audit Toolkit provides a resource for assessing the quality of ethnicity data in NZ primary healthcare settings and supporting quality improvement. While ethnicity data has been collected for several years, the quality and completeness of data is not always sufficient for data to be useful.

Best practice dictates the audit should be completed every three years and is aligned with Foundation Standards Certification.

Find out if / when your practice has completed an ethnicity data audit and if any areas were identified for improvement. Could this be a quality improvement project in your practice?

- Primary-care-ethnicity-data-audit-toolkit-v2.pdf

End of activity

4.3 Health Equity Assessment Tool (HEAT)

The Health Equity Assessment Tool (HEAT) aims to promote equity in health in NZ. It consists of a set of questions that enable assessment of policy, programme, or service interventions for their current or future impact on health inequities. The questions cover the following stages of policy, programme, or service development[10]:

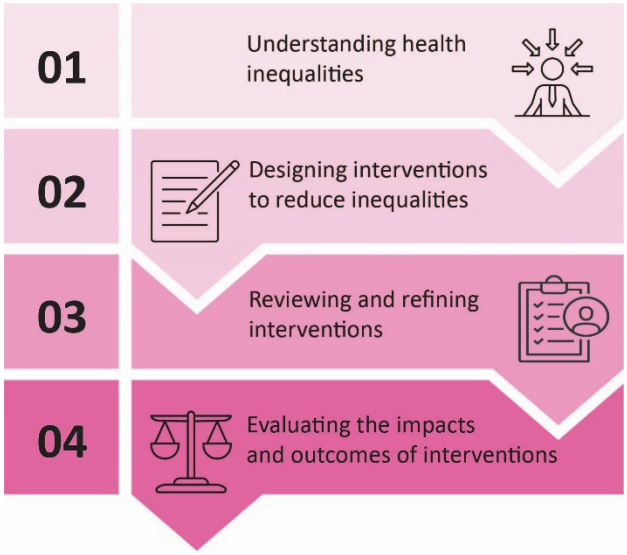


Figure 8: Practice use for the The Health Equity Assessment Tool (HEAT)

Activity 9: Read - Health Equity Assessment Tool: a user's guide

The Health Equity Assessment Tool (HEAT) includes a series of questions to consider (listed below) and challenges users to think broadly about equity issues. Further explanations and details of the questions can be found in the HEAT user's guide, which is recommended reading:

- health-equity-assessment-tool-guide.

End of activity

The Health Equity Assessment Tool (HEAT) provides valuable information. The following is a brief introduction to information contained in the HEAT.

Although the HEAT is designed to evaluate programs for their impact on Māori health outcomes, you could apply the questions to any disadvantaged group for which you are trying to improve equity.

[10] Signal, L., et al, 2008. *The Health Equity Assessment Tool: A user's guide*, Ministry of Health, Wellington, NZ

Test your suspicions by collecting and analysing data and applying the following questions from the HEAT[11].

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?

The HEAT is a flexible tool that can be used in its entirety or, alternatively, selected questions or groups of questions can be asked for specific purposes.

The HEAT questions can be used to provide a quick overview of potential issues and gaps in policies, services, and programmes. Alternatively, more in-depth responses to the HEAT questions can assist in developing an evidence base for policy, service, and programme development and / or evaluation.

Summary

Equity and related quality improvement projects require reliable data. As the practice manager, it is important that you understand the capabilities of your software systems, as the system will have data available for analysis if you know how to access it. However, the data output is only as good as the input, meaning that if patient information is incomplete your data set will be incomplete.

Qualitative and / or quantitative data is necessary to identify existing inequalities in access or outcomes and the evaluation of interventions. There are audit and evaluation tools that will assist you in evaluating equity issues, including the HEAT.

[11] Signal, L., et al, 2008. *The Health Equity Assessment Tool: A user's guide*, Ministry of Health, Wellington, NZ

Lesson 5: Leadership to support equity

At the healthcare practice level there are evidence-based initiatives you can implement to improve equity for your community. As with any quality improvement projects in a busy practice, sound leadership is critical, and the practice manager is well-positioned to lead the practice.

This Lesson introduces the importance of leadership in quality improvement initiatives, and how the typical standardisation required of quality improvement in healthcare can be counterproductive in achieving equity. Strategies for specific initiatives such as health literacy and patient-centred care are introduced.

5.1 Quality improvement and equity

Quality improvement in healthcare has gained significant traction in recent years and is linked to government funding. Patient and practitioner expectations are changing; high-quality healthcare is expected by consumers. Quality improvement initiatives in the health sector frequently focus on standardisation to reduce variation and improve the provision of evidence-based care, as this can improve overall efficiency, effectiveness, and safety of healthcare services.

Standardisation helps to achieve quality improvement by:

- increasing consistence
- reducing unwarranted variation.

Figure 9: Standardisation in quality improvement

However, consider what we have learnt in this Module regarding equity versus equality and then consider how standardisation impacts disadvantaged groups. Do you remember what happens when everyone gets the same bike? This will suit some people; however, others will not be able to ride the standardised bike because it doesn't meet their needs[12].

Standardisation requires everyone getting the same assessment and treatment with the same resources, or **equality.** Equity, on the other hand, clearly identifies disadvantaged groups with poorer health outcomes, and understands that they require different and perhaps more, resources.

So how do you reconcile equity with quality improvement? Some considerations are outlined below.

Ways of reconciling equity and quality improvement

- Initiatives need to be adaptable to local needs, considering the population has different needs and a standardised approach can fail to deliver to those most in need.
- Choose quality improvement projects that have a specific goal to improve access or equity for an identified disadvantaged group, using data to define the problem and measure your success.
- Understand how reliable your practice data is, particularly around ethnicity.
- Apply the 10 questions from the HEAT to your project, to encourage your team to think critically about the quality improvement projects you identify.
- Consider how increased workforce diversity will help the practice to collectively identify areas of need in your community.

[12] Robert Wood Johnson Foundation, 2017. *Visualizing Health Equity: One Size Does Not Fit All Infographic*, URL: https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html Retrieved 1 November 2021

- Equity projects often require a long period of time to see results. does your practice have the resources to sustain and grow the initiative?

5.2 Leading for equity

Inequitable access to healthcare has the effect of compounding inequity, as those most in need of healthcare have the least access to it. Barriers to accessing healthcare include issues with:

- health system literacy
- culturally safe health services
- patient and whānau-centred care.

These topics are all essential knowledge and are covered in detail in *Module 2: Cultural safety*.

Here are some practical suggestions to implement that will help your practice improve equity for your community.

Table 2: Practical steps to drive health equity

Driver of Health equity	Practical steps to take
Cultural safety	• Consider the artwork and signage in the practice. • Use bilingual signage. • Ensure staff can pronounce patients' names correctly. • Diversity in staffing creates diversity in views and life experience. Encourage and support a diverse workforce. • Engage representatives from the disadvantaged groups you are targeting to input into changes the practice could make. • Ensure all staff have received training in cultural safety, including clinical and non-clinical staff. • Encourage staff to understand implicit bias and become aware of their own implicit bias as this is a step towards change. • Critically review your practice for unintentional system issues that may be a barrier to access for disadvantaged groups. • See Module 2 for further information.
Patient-centred care	• Practices learn how to best meet the needs of their population groups by working with patients and whānau. • Partnership with patients and whānau aligns directly with Treaty of Waitangi principles of participation, partnership, and protection. • See Module 2 for further information.
Data and information technology	• Understand what data you have available and if you are using it effectively. • Understand the quality of the data inputs and improve the data collection and data entry if needed. • Focus quality improvement efforts and identify population groups that may need different care to achieve the same result based on reduced access or non-access.
Leadership	• Bold, innovative leadership disrupts the status quo. • Partner with patients and whānau to identify barriers and solutions. • Add standing agenda items to regular team meetings around the drivers of health equity, to ensure the whole team thinks of access and health equity .

Driver of Health equity	Practical steps to take
	• Introduce training requirements, such as cultural safety every two years. • Be prepared to shift the quality improvement focus from quick wins to long term changes. • Model cultural safety by ensuring the leadership team treats everyone (staff, patients, whānau) with dignity and respect. • Learn from other practice's that have successfully used tools such as HEAT, considering which parts of their projects you could replicate, and what lessons can be learnt
Health literacy	• Health literacy is a person's capacity to obtain, process and understand health information and services. • Assume all individuals have some degree of difficulty in negotiating health environments. • The practice is responsible for supplying appropriate information to every patient and their family. • Quality improvement initiatives can focus on removing health literacy as a barrier to access by looking at both the affected population and the practice. • See Module 2 for further information.

To have a positive impact on equity, quality improvement initiatives need to use data to understand the population groups with the greatest healthcare need. These could be groups defined by ethnicity, age, disability, geography, income levels, or something specific to your community. Quality improvement initiatives that provide the disadvantaged population groups with priority interventions to give them fair health outcomes are important in your practice.

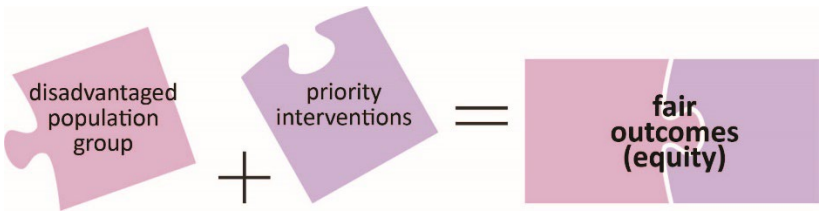


Figure 10: Quality improvement initiatives

The Health Quality and Safety Commission of NZ [13] suggests that when planning a quality improvement initiative, you should ask your team the following questions:

- Who are the individuals and groups in most need of this initiative?
- Is this service able to appropriately approach and be accepted by the individuals and groups most in need?
- Will this initiative be seen, sought, reached, and engaged with by those individuals and groups?
- What institutional and structural barriers prevent the benefits of the initiative reaching all who need them?
- What bias is brought via the design of the initiative and how can this bias be recognised, avoided, or mitigated?

[13] Poynter, M., et al, 2017. *Quality improvement: no quality without equity*, [pdf], URL: https://www.hqsc.govt.nz/assets/Other-Topics/Equity/Quality_improvement_-_no_quality_without_equity.pdf Retrieved 1 November 2021

Activity 10: Find out more

The following article by Browne et al (2012) is optional reading if you would like more guidance on practical steps you can take to address inequity in your practice.

- Closing the health equity gap: evidence-based strategies for primary healthcare organisations

End of activity

Conclusion

In NZ, people have differences in healthcare 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[14]. Disadvantaged groups could be identified by their ethnicity, age, gender, geographical location, sexuality, religion or other contextual factor.

Achieving equity in health outcomes is increasingly a priority for governments, with a focus on multifactorial government approaches. Multifactorial approaches are critical when you consider the complexities of the social determinants of health including housing, education, disability, food security, conflict and other factors. While a healthcare practice cannot change the social determinants of health for their population, the practice can support people from disadvantaged groups to access healthcare. Understanding the national strategic approach provides both the context of the bigger picture you are working within, and the legal obligations with which your practice must comply.

Equity and related quality improvement projects require reliable data. As the practice manager, it is important that you understand the capabilities of your software systems, as the system will have data available for analysis if you know how to access it. However, the data output is only as good as the input. Improving your equity data input may be your first quality improvement project.

From a practice perspective, the practice manager has a leadership responsibility to ensure the practice serves the community; using data and tools to identify target groups, design quality improvement initiatives and evaluate the outcomes. There are audit and evaluation tools that will assist you in evaluating equity issues, including the Health Equity Assessment Tool (HEAT) Guide. Some strategies to improve equity include understanding implicit bias, providing a culturally safe physical environment, support health literacy development, providing person and whanau-centred care. Every step you take to understand and address equity is crucial in supporting fair and just access to healthcare for disadvantaged groups.

Providing culturally safe services is a high priority strategy to achieving equity in healthcare and *Module 2: Cultural Safety* is dedicated to this topic.

[14] Ministry of Health, 2021. *Achieving equity*, URL: https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity Retrieved 1 November 2021

Quiz questions

LD notes: publish as H5P as per current processes. Delete red text when finished.

H5P activity, multiple choice.

Question 1

The World Health Organisation describes the Social Determinants of Health having significant impact on equity of health outcomes. Which of the following are Social Determinants of Health?

Select all answers that apply.

- income and social protection
- education
- unemployment and job insecurity
- early childhood development
- food insecurity
- social inclusion and non-discrimination

Answer / H5P feedback

Answer text / Sample response guidelines here

- *income and social protection*
- education
- unemployment and job insecurity
- early childhood development
- food insecurity
- social inclusion and non-discrimination

LD notes: publish as H5P as per current processes. Delete red text when finished.

Explain type of H5P activity, true/ false

Question 2

Is the following statement true or false? Disadvantaged groups need more resources and a different approach.

true/false

Answer / H5P feedback

- *True. Equity requires different resources and a different approach for disadvantaged groups*

LD notes: publish as H5P as per current processes. Delete red text when finished.

Explain type of H5P activity, e.g., drag and drop

Question 3

Match the correct definition to each word.

Implicit bias =

Explicit bias =

- biases we are aware of on a conscious level
- attitudes and beliefs that occur outside of our conscious awareness and control

Answer / H5P feedback

- *Implicit bias = attitudes and beliefs that occur outside of our conscious awareness and control*
- *Explicit bias = biases we are aware of on a conscious level*

End of activity